Neoliberalism and Health Services in Bihar: Deconstructing Public-Private Partnerships

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DECLARATION

I declare that the thesis entitled "**Neoliberalism and Health Services in Bihar: Deconstructing Public-Private Partnerships**" submitted by me for the award of the degree of **Doctor of Philosophy** of Jawaharlal Nehru University is my own work. The thesis has not been submitted for any other degree of this University or any other university and is my original work.

Pratyush Singh

CERTIFICATE

We recommend that this dissertation be placed before the examiners for evaluation.

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Completing is a Ph.D. thesis is not a one person's job. One needs more than academic orientation, a research aptitude, writing skills and an in-depth knowledge of one's research area. To successfully complete a Ph.D. thesis, I have realized, one needs a brilliant support system. Generally, family and close friends become that support system helping someone to stay afloat when things become overwhelming. I was so fortunate that my supervisor Prof. Rama Baru, a brilliant academic, did not only guide and support me in the process of my research but she was also a part of my support system. And God knows I have needed her kind words of encouragement to carry on. Her academic excellence is well known in the field of public health and I have benefitted immensely from her guidance. My family has been a source of unwavering support for me all these years. I am just so grateful to my parents for being so kind and generous. I don't know how they have been so patient with me. They live in a society, where having a grown man dependent on his parents is frowned upon but my parents never exposed me to the negativity, the sarcasm and the resentment that they had to face because of me. I wish I had been as patient and kind to them as they have been to me. I am so grateful to my sister for being such a great sibling, I am in her debt, quite literally. It never stopped her from making her own life a bit harder in order for me to have things easier. I am thankful to my brother who stood with me in every decision that I took, even when he did not agree with them. Living in his close proximity gave me much needed comfort. I have a lot to be thankful to my wife who has been an exceptional partner to me. I am not an easy person to live with and my penury only made living with me even less appealing and I cannot imagine how she has managed to live with me. Unlike me, she has been so generous, with her confidence in me, with her compliments, with her help, especially academic and very importantly, with her money. As I write this its dawning on to me how I am surrounded by people who love me and care for me and want me to happy and so something worthwhile in my life. I am forever indebted to my friends and family. I also wanted to acknowledge the help of respondents who were kind enough to give me their time and their valuable inputs for my research.

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Abbreviations

ADB	Asian Development Bank
AIMA	All India Management Association
AWC	Anganwadi Centre
BDPL	Bihar Development Policy Loan
BMGF	Bill and Melinda Gates Foundation
BMSICL	Bihar Medical Services and Infrastructure Corporation Limited
CAG	Comptroller and Auditor General
CII	Confederation of Indian Industries
CMO	Chief Medical Officer
CS	Civil Surgeon
CSR	Corporate Social Responsibility
DEA	Department of Economic Affairs
DFID	Department for International Development
EOI	Expression of Interest
FRBM	Fiscal Responsibility and Budget Management
GDP	Gross Domestic Product
GOB	Government of Bihar
GOI	Government of India
HMIS	Health Management Information System
HWS	Health and Wellness Centre
ICDS	Integrated Child Development Scheme
IDA	Infrastructure Development Authority
IEA	Institute of Economic Affairs
IFC	International Finance Corporation
IIPS	Indian Institute of Population Studies
IMF	International Monetary Federation

IMR	Infant Mortality Rate
JDU	Janta Dal United
MOHFW	Ministry of Health and Family Welfare
MOWCD	Ministry of Women and Child Development
MMR	Maternal Mortality Ratio
MNGO	Mother NGO
MPS	Mont Pelerin Society
NDA	National Democratic Alliance
NFHS	National Family Health Survey
NGO	Non-government Organization
NHA	National Health Accounts
NHM	National health Mission
NHS	National Health Service
NHSRC	National Health Resource Centre
NMR	Neonatal Mortality Rate
NPM	New Public Management
NRHM	National Rural Health Mission
NSSO	National Sample Survey Organisation
OECD	Organisation for Economic Co-operation and Development
OOPE	Out of Pocket Expenditure
OPPI	Organisation of Pharmaceutical Producers of India
PIP	Program Implementation Plan
PPP	Public-private Partnership
RCH	Reproductive and Child Health
RGI	Registrar General of India
RHS	Rural Health Services
RJD	Rashtriya Janata Dal

RNTCP	Revised National Tuberculosis Control Program
SAP	Structural Adjustment Policy
SHS	State Health Society
SRS	Sample Registration Survey
THE	Total Health Expenditure
TOR	Terms of Reference
UN	United Nations
UNECE	United Nations Economic Commission for Europe
UNICEF	United Nations International Children's Emergency Fund
USAID	United States Agency for International Development
U5MR	Under Five Mortality Rate
WHO	World Health Organization
WBG	World Bank Group

Chapter 1

1.1 Introduction to this research:

Bihar is home to more than ten crore people; it is India's poorest state and has some of the worst development indicators in the country. Improving people's health status has been a huge challenge not only for successive state governments but also for national and international aid organizations. The state has also been one of the special focus states under the Indian government's National Health Mission from its inception. Health sector in Bihar has been dominated by the private sector, 80% of out-patient and 65% of in-patient services (excluding childbirth) are provided by the private sector (NSSO, 2019). There are several reasons why utilization of public health facilities in the state is low; poor quality of care is the biggest factor that stops people from availing public health facilities (IIPS, 2022). Other major factors include distance of the health facility, lack of health personnel and the larger wait time in these facilities (Ibid). Public health sector in Bihar is in a bad state and most public health facilities fail to meet the revised IPHS norms in terms of health human resources and health infrastructure (NITI Aayog, 2021). According to the Rural Health Statistics (RHS) data of 2019, there was a shortfall of 39% PHCs, 41% sub-centres and 81% CHCs in Bihar (MoHFW, 2019). Composition of the private healthcare market in Bihar is also unlike any other state: 65% of health services in Bihar provided by a private doctor or a doctor in his private clinic against a national average of 43% and 11% of the services in Bihar were provided by the informal healthcare providers compared to an average of 3% in other states (Ibid). This means that the health sector in Bihar is extremely unorganized, informal and individualized and therefore difficult to regulate. A larger and mostly unregulated private sector has led to high out of pocket expenditure causing severe financial hardships for families. According to a report by the National Health System Resource Centre, 13% of the OOPE in Bihar proved to be catastrophic; meaning that they had to spend more than 10% of their total household expenditure on healthcare that led to their impoverishment (NHSRC, 2015). In terms of key health indicators, Bihar is also one of the worst performing states in the country. Nearly 70% of the children under the age of five are anaemic in the state according to the fifth round of NFHS, 66% of young women in the age group of 15-19 years are also anaemic. Of every one thousand children born, 34 die within a month, 47 die within a year and 56 children don't live for more than five years (IIPS, 2022). Maternal Mortality Ratio in the state is 149 per 100,000 live births against the national average of 122 (RGI, 2021). In the ranking of states done by NITI Aayog based on their performance in key health indicators, Bihar was the second worst performing state in

India in 2018 (NITI Aayog, 2020). The state is still struggling to control some of the neglected tropical diseases that are no longer prevalent in other parts of the country like Kala Azar and Filariasis (Kumar, et al., 2020).

This has been the case despite the fact that the state has been one of the best performing states in India in terms of economic growth, often scoring higher GDP growth rate than the national average (GOB, 2021). High economic growth, low state funding in healthcare, contractualisation and unregulated private market are characteristics of the health sector in Bihar. It was one the first states to generously adopt the PPP model after the advent of NRHM. An acute increase in central funds and lack of public health infrastructure to fully utilize those funds pushed the state towards private partners. The strategy was also compliant with the pro-PPP strategy of the RCH program in particular and the NRHM in general. After nearly two decades of extensively relying on PPPs, the health system in the state continues of be enervated. Key indicators on health financing, human resources, regulatory mechanisms, medicines and vaccines etc. are either more or less the same or only marginally better when compared to the beginning of the NRHM. That begs the question; do PPPs contribute towards health system strengthening? If they don't what are the reasons for the overwhelming support that it has received from policy makers, funding agencies and think-tanks. The economic, social and political context in Bihar is unique, making implementation of PPPs in the state an intriguing and interesting study area, the PPP project is as much national and global as much as it is sub-national. Nature of the public and the private health sector in the state also impinges upon the history, present landscape and composition of PPPs in the state. Bihar is a case where a large private sector, significantly unorganized and mostly unregulated and a relatively small public health sector that is not a preferred choice of people partnering in a political economic context where the monitoring and regulatory capacity of the government is poor. Such a context poses significant challenge in developing partnerships where the interests of both partners are equally or proportionally protected and the ultimate goal of improving people's health is achieved.

There has been a massive effort to promote PPPs in healthcare; the figureheads of this global phenomenon are the international development banks aided by management consultants and neoliberal think tanks (Wettenhall, 2003). Several reports published by these organizations have been published over the years arguing how beneficial PPPs can be in the health sector; seldom these arguments are backed by evidence (Ibid). However, peer reviewed academic literature is not as unanimous in its uncritical praise for PPPs; there is a large body of literature

that underscores that the buoyancy of the PPP narrative is held up by mere assumptions and vested interests. Even those who are actually optimistic about PPPs do so with several caveats; like having a strong public sector, equal sharing of risks, need for monitoring and evaluation mechanisms and ensuring social welfare instead of profiteering (Savas, 2000), (World Bank, 2014). However, the public policy discourse not only in India and in Bihar but even globally has been informed and directed by the uncritical, full of praise literature surrounding the role of PPPs in healthcare, while choosing to ignore the small yet strong evidenced backed literature that is wary of this blind rush towards PPPs.

This of course, is not an organic and involuntary phenomenon but a conscious policy decision that is being influenced by the international and national agencies and is influenced by the overarching context of neoliberalism that has decisively moulded the economic systems of the world for at least half a century now. Neoliberalism is not a well-defined ideology and to say that neoliberalism is a complicated and perhaps an ambiguous concept has become a cliché now. However, that in no way suggests that it is an esoteric idea. It is an abstraction capable of multiple interpretations and shades of meaning. However, historically and epistemologically, it is a political economic ideology more than anything else, which believes in the supremacy of the free market. Neoliberalism reimagines the state-market relationship, where the role of the state in economic activities is undesirable and even dangerous. It is only supposed to interfere in the unrestricted moorings of the self-correcting, omnipotent market to ensure that the driving spirit of a capitalist economic system i.e., competition is threatened (Harvey, 2005) (Navarro, 1998) (Hayek, 2001). Its current popularity among political and policy leaders stems from the fact that it appears to offer a value-free system of decision making, since neoliberalism is driven by the ideas of competition and efficiency and maintains its distance from all political ideologies.

Privatization has been one of the most potent tools of market expansion under the neoliberal system. Purveyors of the neoliberal ideas that includes international think tanks, consultants and banks have been singing paeans of privatization for decades until the lates 2000s, when it was realized that the discontent against privatization and its promise of trickle down, had grown so much that it was putting the whole neoliberal ideology at risk. The building up of the pro-PPP rhetoric, especially in the healthcare sector also seems to overlap with the decline of the privatization rhetoric (Wettenhall, 2003).

Decline of the Keynesian welfare and developmental state in the 1970s brought into question the traditional role of bureaucracy and state-owned enterprises. The belief that bureaucracies and management of the SOE were inefficient, slow, ineffective and unresponsive gained a lot of popular and policy currency. On the other hand, the private sector was looked at as an embodiment of efficiency and responsiveness. There were attempts to make the public sector adopt the management practices and techniques that are followed by private enterprises making them more efficient. This phenomenon of public sector organizations adopting private sector practices came to be popularized as the New Public Management reforms (Hood, 1991). In several countries with emerging and growing economies, NPM became an important part of their economic reforms that were adopted to tackle the debt crisis in those countries. An overarching agreement among lending organizations to incorporate NPM tenets in their recommendations/conditions was arrived and came to be known as the Washington Consensus. Proposed and endorsed by three Washington based financial institutions namely the World Bank, International Monetary Fund the US Treasury, these policy recommendations were targeted towards stabilisation, liberalisation, and privatisation of debtor country's economy. Most often, these reforms were imposed upon on less developed economies reeling under financial distress as a condition for financial assistance and debt relief.

Even though SAP led to the introduction of health sector reforms in India, the grounds for that had been prepared since a decade ago. By the 1980s the importance of healthcare sector in market expansion was realized during this time. Healthcare in India has always been dominated by the private sector, which has been allowed to function with little to no regulatory compliance. Although health was still considered to be government's responsibility and various reports stressed the importance of the same, material progress towards that vision was amiss. Therefore, neoliberalization of the Indian healthcare sector did not face a formidable challenge from the governments. The only resistance it faced was from the civil society and public health workers and scholars. During the seventh five-year plan (1985-1990), family planning services were opened for the private sector (Qadeer, 2008). The neoliberal agenda was further entrenched towards the end of 1980s and the beginning of the 1990s with the adoption of the health sector reform measures recommended by the world bank. It was Introduction of user fee in public hospitals, which was the first and one of the most significant 'reforms' that was introduced through the eighth five-year plan (Planning Commission, 1992). The rationale was that people with the ability to pay, should be charged at least a small amount for the health services, and the government should focus its efforts and resources on targeting the

underprivileged sections by providing primary healthcare and implementing national health programs (Qadeer, 2008). By the middle of the 1990s, majority of Indian states had implemented 'user fee' model in their public healthcare facilities. The impact of the neoliberal reforms was majorly felt in three categories; reduction in government investment in health, privatization of healthcare and donors driving public health priority (Qadeer, 2000).

It's very important to look at how PPPs have affected the health systems in Bihar for one simple reason; the inexplicable uniqueness of the state which means that the models or previous experience or experience from other countries and contexts is unlikely to be replicated in Bihar. For instance, while the rest of the country was experiencing economic growth in the post liberalization era, Bihar was undergoing through one of its worst economic years. The nature of the state-market relationship in Bihar is also unlike any other state in India where both market and the state has failed to ensure health and wellbeing of its people. There is no model to analyse PPPs in healthcare in case of this twin failure; PPPs are normally agreements where the two partners i.e., the state and the market, represented by the government and a private agency agree to complement each one's weakness with the other one's strength. But what if both of them are weak? What are the chances of them having a strong partnership? Will they achieve something together, which they couldn't achieve individually? These are questions that are uniquely applicable to Bihar. Another rather distinctive feature of Bihar, or the health sector in Bihar to be more precise is the nature of its market. Until a few months ago, there was no corporate presence in the health sector in Bihar; the private providers were dominated by small nursing homes/hospitals and individual doctors and informal providers. That means the healthcare market is more unorganized and therefore more difficult to control and regulate.

The year 2005 is a significant milestone for studying PPPs in the health sector in Bihar. The National Rural Health Mission (NRHM) was launched in 2005 and the Bihar was one of the special focus states of the Mission owing to the weak health system in the state and poor performance on key health indicators. NRHM adopted 'promotion of public-private partnerships for achieving public health goals as one of its five supplementary strategies (MoHFW, 2005). The sudden increase in inflow of funds meant that states like Bihar that did not even have the capacity to fully utilize the money opted for partnerships as an immediate and less challenging alternative. The periods before and after 2005 are starkly different in terms of administrative and governance changes, market sentiments, public perception and economic growth. Although many of the structural challenges that the state faced before 2005, still

remained during the post 2005 era, a distinct increase in economic growth is a defining characteristic of the time period.

Traditionally, PPPs have been studied as a collaborative mechanism between two distinct and sometimes competition entities, each with their own strengths and weaknesses have figured out this novel arrangement where both can benefit from each other's virtues, simultaneously mitigating the risk for both by sharing it. However, PPPs should neither be viewed nor as a form of neoliberal governance model that is highly privatized or a fundamentally innovative model to overcome the limitations of the public sector. Rather, PPPs must be viewed as a concerted political and economic attempt to further entrench private sector interests and its values within an already declining public sphere by altering/blurring the boundaries between the public and private spheres (Baru & Nundy, 2008). PPPs are essentially a part of the evolving global neoliberal strategy of expanding the reach of markets to previously closed spheres of the economy (Peck & Tickell, 1994).

PPPs are often looked at in the context of the virtues of either the public or the private sector. Advocates extol the virtues of private while critiques highlight the weaknesses of private. And it is the general proposition that the relationship is complementary, where one partner lags, the other excels. However, Bihar is one place where this framework of looking at PPPs is just inadequate. The argument that PPPs can provide the capital investment in healthcare that resources starved economies simply can't afford to has a very limited evidentiary basis. As is evident from a large number of PPPs in Bihar, that unlike the high-income country model of PPPs that was based on the private financing of a healthcare project, PPPs in less developed settings are primarily used for provisioning of services. Therefore, one of the basic tenets of PPPs that they provide financial succour to cash starved economies fails to apply in Bihar. Lack of state's capacity and its ability to play the dual role of a partner as well as a regulator is a major hinderance towards an efficient partnership. The situation becomes further challenging when in addition to poor government capability is, there are not enough private providers in the market to assure competitive pricing. The world bank has also warned that a weak state regulatory system could be a hindrance in a sustainable PPP model, it argues for an unambigous legal and regulatory framework. Bihar is a classic example of such a weak regulatory state, framework to regulate the private healthcare sector including diagnostics and pharmaceutical are virtually missing in the state.

There is a huge gap in available literature both at the level of research studies and at the level of policy documents when it comes to public-private partnerships in healthcare in Bihar. A study by Mona Gupta in 2009 and another case study of PPPs in radiology services was published by OXFAM in 2017. A set of evaluation studies was published by the researchers who were part of the Ananya program funded by the Gates Foundation beginning with a baseline survey in 2014 (Kumar, et al., 2014). Sulakshana Nandi and others published their three-state study to a performance review of healthcare PPPs and evaluate their contribution towards Health System Strengthening; Bihar was one of the three states (Nandi, et al., 2021). One more unpublished study that dealt with the PPPs in diagnostic services is the M.Phil. dissertation by Chandan Kumar (Kumar, 2013). Considering that Bihar was one of the first states to adopt and implement public-private partnerships after the country wide implementation of NRHM, this gap is disconcerting. The Bihar State Health Society (BSHC), which is the nodal agency for the National Health Mission in Bihar has no document that deals with the conceptual framework of PPPs in healthcare or the challenges towards their successful adoption. There is also a palpable lack of government documents evaluating older PPPs; such studies could provide valuable insights from hindsight and directions for future.

Public-private partnerships in health raise very important ethical questions on the role of the private sector in public health. Where does the ultimate responsibility of ensuring health and well-being lie? Can corporations be awarded rights similar to individuals, and if such rights are accorded to them then how will accountability and responsibility be fixed? How will social justice and profit accumulation co-exist? What role the state would play; of a regulator, provider or facilitator of services? These questions have no clear answers, but the positive change claimed to be brought by PPPs is yet to be demonstrated with evidence. The Indian health policy and planning documents have praised the PPP model, but the model adopted is riddled with contradictions. Bihar is one of the cases which bears witness to failure of both, the market and the state. Even though private health care constitutes as much as 80% of the total health services, still there is a huge market failure in terms of spatial availability of health services. The rural urban divide is stark in terms of availability of health services. In a scenario where the public infrastructure in health is dismal and private services are enclaved, it seems like a bleak future is imminent for the health status of people of Bihar. Through this research, a better understanding of the shortcomings in PPPs will also help the health policy to be more discerning in evaluating PPPs and become more empowered to get an equitable and socially beneficial partnership. Such understanding is imperative for the state of Bihar as the presence

of the private sector in healthcare is huge and the government has been leveraging this presence in an attempt to increase access to healthcare for the state's people.

It is important to analyse PPPs in the context of neoliberalism. The pattern of expansion, strategies adopted, ideological grammar are eerily similar. The institutions who promote neoliberal policies are the same ones who also promote PPPs. It is the dominant ideology that permeates public policy landscape of many developed as well as less developed countries (Navarro, 2007). It also drives policies of international agencies like the World Bank, International Monetary Fund, World Trade Organization; its impact is apparent on development organizations such as the World Health Organization (Ibid).

1.2 Objectives of this research:

- To examine and deconstruct the conceptual discourses of 'Public', 'Private' and 'Partnerships'.
- To understand how PPPs affect the health system at the sub-national level.
- To understand the role of global and local structure, actors, and ideas and narratives that enable the development and practice of PPPs.
- Understand in what ways Neoliberalism is similar to other forms of free-market capitalist ideologies and what makes it a novel idea.
- How does public-private partnerships fit into the neoliberal healthcare model.
- To understand how the 'rolling out' of neoliberal ideas have been different in Bihar and what are the social, political and economic factors affecting it?

1.3 Research Questions:

- What is the political-economic philosophy behind public-private partnerships?
- What is the role played by development banks and consultancies in promoting and entrenching the idea of PPPs in Healthcare?
- What are the factors that affect PPPs at the sub-national level?
- Do PPPs in Healthcare lead to public health system strengthening in Bihar?
- Are PPPs a neoliberal strategy for market expansion?

1.4 Research Design

1.4.1 Conceptual Framework

Concepts used:

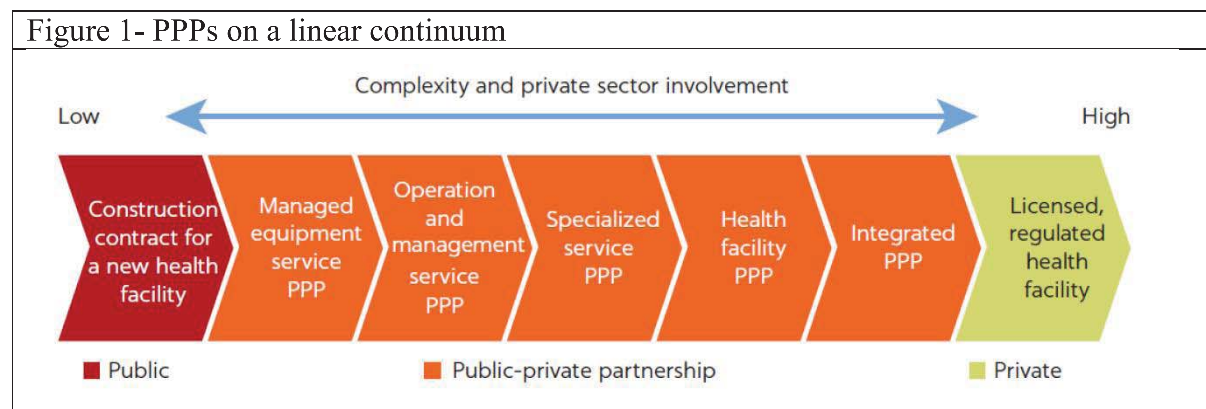
- State refers to the political governance structure of a country/state.
- Markets will include all private economic structures facilitating production and exchange in the economy.
- Public will refer to all institutions that are owned, controlled and managed by the state. These include both constitutional and statutory bodies.
- Private will include all institutions including individual entrepreneurs whose ownership, control and management is not done by the government. These are entities that have a majority non-governmental ownership, i.e., 51 percent or more. This includes both for-profit and not-for-profit organizations as well as private philanthropic foundations.
- Organizations like the WHO, UN, World Bank etc are referred to as multilateral organizations as their ownership, control and management is divided amongst various countries and organizations.

PPP in healthcare has a genealogy, it has a philosophy and it has grown in a particular economic context. And to understand it, we must deconstruct it. The genealogy calls for contextualizing PPPs in the concepts of privatization, liberalization, marketization of healthcare.

Given the variations that exist in how PPPs are defined, it becomes absolutely elemental for this research to identify and engage with the philosophy behind this arrangement. The underlying philosophy behind the idea of PPPs is that markets are as good as if not better as providing healthcare to everyone. In fact, markets have the capability to make up for failure of the state. Once this philosophy is discerned it becomes clear that PPP must be analysed in the context of the state vs market debate that has formed the core of capitalist economic narratives for more than two centuries. And the dominant form of the global capitalist economy i.e., neoliberalism must be decoded and its intellectual history must be chronologized to fully understand its workings in the current form. Without putting the march of PPPs in the context of neoliberalization one can't make a sense of the burgeoning progress it has made since the late 2000s. Even though the 'grammar of privatization' was shunned by the neoliberal agenda in response to the overwhelming global public opposition; the agenda of privatization was not. As the discontents of privatization began to turn into discontent against markets as a whole and threaten the neoliberal model itself, it was rather ingenious to adopt an alternate strategy of market expansion that will ultimately lead to more privatization without going through the rigmarole of erstwhile privatization strategies.

Most often the literature on public-private partnerships locates them on a linear continuum; where the health sector is displayed as a line, one end represents a highly privatized form while the other signifies high involvement of the public sector (Fig. 1). Irrespective of the ends, private sector is always present as an important part, albeit on a varying proportion vis-à-vis the public sector. PPPs are shown to exist the middle of the continuum of public and private models of financing and provisioning.

Figure 1- PPPs on a linear continuum

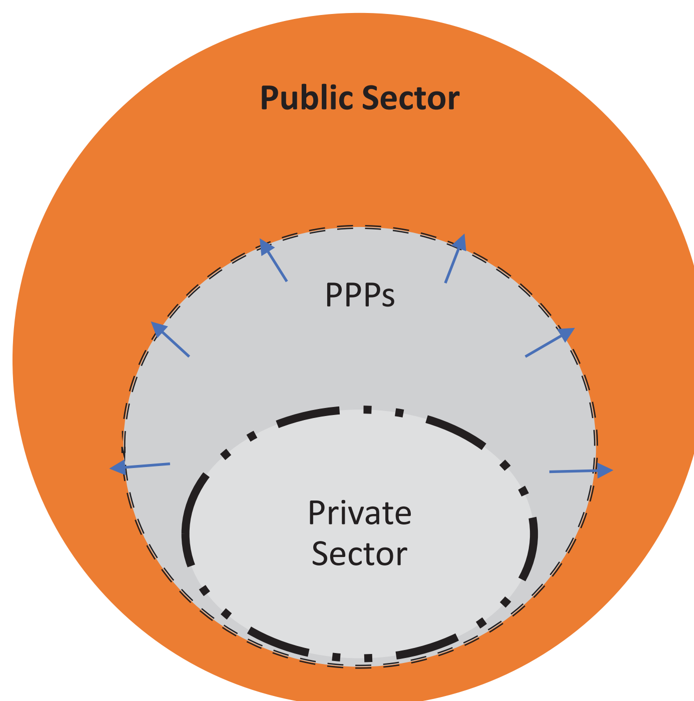


Source: The World Bank Group (World Bank, 2020)

Private activity in any capitalist economy is dependent on public authority. From de-regulation to protection of property, markets need states to survive and thrive. Therefore, PPPs must be conceived as a meeting place for the public and the private, instead it should be looked at the place where boundaries between the public and private spheres are rearranged or as very pertinently described by Rama V. Baru and Madhurima Nundy; 'blurred' (Baru & Nundy, 2008). Although in their article the authors have used the idea of blurring of the roles of the state as a buyer and the private partner as a supplier in a PPP, arguing that the buyer-supplier split is not clearly demarcated as the supplier is prevented from questioning the government/buyer owing to their dependence on the latter (Ibid). It is also convenient for the buyer to leave the everyday functions of the services to the supplier/partner (Ibid). I have developed this idea further to argue that due to the change in roles of the government and the private sector, accentuated by the neoliberal framework, a clear distinction between their roles becomes extremely difficult. This blurring of the roles also affects the ambit of the partnerships as between them as well as their composition and nature. Arne Ruckert & Ronald Labonté in their work on PPPs, suggest that reshaping of the public and the private realms is inherent to PPPs allowing the private to be embedded in the public realm even further, which empowers them to grow their influence on national and global health policy (Ruckert & Labonté, 2014). This research conceptualizes the health sector not as a sum its separate public and private parts

where each is vying and competing for a bigger pie, rather it conceptualises the health sector as a social, economic and political totality in which the private sector is circumscribed by the public realm. The two concepts used by Baru and Nundy and Ruckert and Labonte have been merged and adapted in the form of a figurative model below. The visual representation below is important (Fig. 2); PPPs and privatization are two different shades of the same ideological belief system that gives primacy to the market forces over any other alternate economic mechanism. PPPs are an important instrument in the realignment of responsibilities by constantly pushing outwards and marketizing increasing number and categories of public goods and services.

Figure 2: Conceptual representation of PPPs ensconced within the public



Source: Adapted from (Baru & Nundy, 2008) and (Ruckert & Labonté, 2014)

Anyways a precise distinction between the public and private is not easy to define. In real life contexts the distinction becomes even more challenging as their respective roles become more conflated. However, PPPs constantly re-align the market-state boundary, in a way making it osmotic, where the market in increasingly infringing upon the previously state dominated sectors of the economy.

After establishing the ideological, intellectual and historical factors that encompass the seemingly value-free idea of PPPs, this research will look at their impact on a sub-national

health system and inquire if they contribute to health system strengthening. Health system strengthening interventions are generally system level interventions that not only impact one specific building block of a health system but has the ability to impact more than one building block. Now, partnerships at the face value might look like system level interventions because they are used across disease categories or across a range of health services. If one looks beyond individual partnerships and looks at them conceptually as one category of health intervention, one must answer the elementary question- why are PPPs implemented? Prima-facie, a diagnostic services PPP is implemented to provide diagnostic services, partnerships in TB control are designed to increase the reach of treatment, a build-operate-transfer type PPP is implemented to make a health facility, so on and so forth, the purpose of these partnerships are wide-ranging and disparate to be categorized as one intervention. However, there is a uniformity beneath all the disparity that makes the idea of considering PPPs as one form of health interventions perfectly logical and tenable. In a state like Bihar the most important reason for implementing PPPs in any category is the state's incapability to provide those services by itself. In PPP as well in NPM literature, this lack of capacity is further delineated on different tangents, for instance, the state is not efficient, it can't access far-off communities and its lacks the technical, clinical or managerial expertise. Therefore, conceptually PPPs in their current form can be considered as a group of interventions that fundamentally target lack of government's capacity. And like any other intervention, it is necessary to understand if PPPs are contributing towards health system strengthening, especially if a state has been relying on them as its go-to strategies for over one and a half-decade now. It is imperative that such a significant health intervention not only at the national and sub-national level but the global level is looked at from a health system strengthening framework. Health systems are not only critical in preventing and treating ill-health but they are also at the core of health inequity and influence the larger issues of social justice. They are now widely recognized as a vital element of the social fabric of every society (WHO, 2008).

After trying several alternate strategies over the years, the global public health community has arrived at an overarching consensus that a robust health system is sine-qua-non for the successful implementation of any health intervention and that health system strengthening should be a part of the strategic objectives of all health interventions. One of the most significant barriers to scaling up public health programmes is the failure or inadequacy of health systems. The scope or the ambit of existing public health interventions to reach

individuals in most need, in a comprehensive and appropriate manner, is not matched by the ability of health systems to deliver them.

Strengthening a health system practically means introducing health interventions that directly or indirectly affect the six internationally accepted health system building blocks that also reflect the basic health system functions, namely, healthcare delivery, human resources for health, health financing, health governance and health information, medical products and technologies (WHO, 2010). A well-performing and a strong health system is one that can sustainably achieve desired health outcomes ensuring initiatives and measures to continuously improve these six inter-related factors (USAID, 2021).

1.4.2 Theoretical framework:

Theoretical framework is understood as a lens through which a researcher views and interprets the world (Luse, et al., 2012). Choosing a theoretical framework can not and should not be a random and arbitrary exercise, rather it should be a reflection of a researcher's personal beliefs and attitude towards things and also his/her understandings of the nature of knowledge itself, how it is to be interpreted, and tools to be employed consequently, by the researcher in his/her work to analyse it. The theoretical framework is considered to be the "blueprint" for the entire research inquiry. It serves as a foundation on which research is built and also a guide that constantly directs the study in the right direction. It also provides the structure, which helps to define how the researcher will approach the thesis methodologically, epistemologically and philosophically and how will he/she will analyse the findings (Grant & Osanloo, 2014).

Public-private partnerships present a microcosm of this centuries old debate, albeit with a slightly different grammar. Public goods and services that were traditionally considered state's prerogative and its responsibility are now being provisioned by private entities through PPP arrangements. This research attempts to investigate how these arrangements have made the public-private boundaries more permeable to the benefit of the private players in the market. This research analyses PPPs by addressing the logic and processes of neoliberalism; so that both the 'why' as well as the 'how' of these partnerships is deconstructed in the broader spectrum of the state vs the market debate.

Considering the state vs market ideological thread runs through the entire thesis, the Political economic framework is the most appropriate theoretical framework that can bind this otherwise disparate looking collection of themes. Political economy as a theoretical enterprise, that

identifies and attempts to define/ redefine associations between politics and economics; it also builds those relations wherever they are not apparently present.

The Marxian political economy approach situates neoliberalism as one of the phases in capitalism's long history, which is very important because it gives the researcher the benefit of context; to know what were the factors that led to the failure of the model that neoliberalism replaced and what were the theoretical promises and premises that it made vis-à-vis its predecessors. In a way, to really understand neoliberalism means constructing a theory of capitalist change (O'Connor, 2010).

When use of the term political economy first began in the eighteenth century, it was to mark a departure from the traditional approach that economic studies had taken. The older term 'economy', literally meant household management and the newer term 'political economy' referred to the realm of managing the economic activities of a state (Hahnel, 2014). The emergence of political economy also brought with itself a debate or an ideological conflict over the role of the state with regards to the economic affairs of the society. The conflict not only goes on but it continues to occupy a central position in the political economic discourse that persist today. Does political intervention in the economy enhance or impede economic activity and subsequently people's welfare is the central question that lies at the core of all macroeconomic debates in one form or another. At various times in history different approaches have weighed in differently on the role of the state; from classical theory that claimed that capitalism will eventually depoliticize the economy to Marxian theory that proposed that economic systems are not only closely linked to politics but they produce structures that define extant political systems (Coporaso & Lavine, 1992). At the core, the neoliberal ideology also attempts to answer this centuries old question in its own way and vanguards of neoliberalism from Friedrich Hayek to Milton Friedman, have grappled with this question at length.

Another theoretical framework that encompasses this research inquiry is the WHO's Health Policy and Systems Research (HPSR) framework. HPSR is defined by the WHO as the category of research that attempts to understand how societies decide on their collective health goals and how different agents/actors interact in the health policy landscape to achieve those goals. HPSR is interdisciplinary that contains a blend of economics, politics, public health and sociology to comprehend how health systems respond to health policies and how both of them shape each other (Alliance for Health Policy and Systems Research, 2011). There are four

central elements of HPSR namely, Health Systems, Health system strengthening, health policy and health policy analysis (Ibid).

It uses the HPSR framework and has adopted a relativist perspective while conducting this enquiry. The key characteristics of HPSR are that it is multidisciplinary and therefore, is driven by research questions rather than methodology (Alliance for Health Policy and Systems Research, 2007). Unlike epidemiological research, where methodology is as important, if not more, as the research questions themselves. In addition to addressing national and sub-national issues, it also addresses global factors as international agencies have major influence on the health systems of low- and middle-income countries. It also addresses the policies of health systems and health system strengthening (Ibid).

One of the critical components of a good quality HPSR is an 'active process of questioning and checking during the inquiry, asking why and how things have happened to develop a deeper understanding of the issue at hand (Gilson, et al., 2011). As a perspective, political economy postulates a relationship between two discrete phenomena, that is economics and politics. As a concept political economy argues that the relation is not external to economics and politics, but the two constitute each other. A political economy understanding of societies makes clearer why and how specific policies are implemented in different places and times (McCartney, et al., 2019). This research focusses on four main aspects of public-private partnerships in health; political, economic, health systems and health policy. A political economic framework allows a researcher to look at the interactions and the intersections of three out of the four aspects.

1.4.3 Research Methodology:

In the final stages of conceptualizing this research, I had realized that there is a huge chasm in terms of availability of PPP literature focussing on Bihar compared to the availability at the national and the global level. There is a large body of literature available on the role of PPPs in healthcare in the Indian as well as international context; their quality, criticality or whether or not they are evidenced based aside. However, when it comes to Bihar there is an apparent lack of literature on the role of PPPs in the state, therefore, collection of primary data was essential. The Semi-structured interview method with key respondents sampled from health managers from the government, public health experts and representatives of partners engaged in PPPs have been used to obtain primary data pertaining to PPPs in Bihar. These interviews have allowed me to get an 'inside-out' perspective on PPPs in healthcare in Bihar. Respondents were selected both from the public sector as well as the partnering private sector. This

purposive sampling of respondents was done so that perspectives of all major stakeholders is included in the analysis making it more comprehensive and robust. Selection of respondents was neither random nor done from a pool of respondents as it was very difficult to find people either in the government/SHS or the private partners who were ready for an interview. Eventually, I was able to find two respondents from the SHS through a personal contact in the NHM. As far as respondents from the private partners are concerned, I was able to interview an employee of the partner company providing diagnostic services. Two respondents working with one of the largest not-for profit organizations working in the state were also interviewed. Two former consultants, one from NHM and the other from NHSRC who had previously worked on Bihar were the independent expert respondents. Other than these interviews, I also conducted semi-formal interviews with two researchers who have worked previously in Bihar. These semi-formal interviews, although meant for me to just get an overall context of the public health landscape and the research environment in Bihar, turned out to be extremely insightful and sometimes more informative than my formal respondents who were extremely measured in their responses and I felt that many a times did not give an honest response if it was critical of the government, which was several times.

Respondent number	Role/ Affiliation	Date/s of Interview	Mode
1	Senior level program Manager in the state	03/03/2019	Personal
2	District Program Manager	13/03/2019	Personal
3	Former NHM consultant presently working with a partner not for profit organization.	03/ 2019 07/03/2022	Telephonic
4	Former NHSRC consultant working in Bihar.	25/06/2019	Telephonic
5	A Partner not for-profit Organization	16/06/2022	Telephonic
6	Same as above		Personal
7	Researcher from an international think tank, worked in Bihar	31/10/2021	Telephonic
8	A Partner not for-profit Organization	07/2021, 12/04/2022	Personal, Telephonic
9	Independent expert associated with a Delhi based organization	14/06/2022	Telephonic
10	Independent expert, RTI activist, health activist	07/2019	Personal
11	Partner organization: a for-profit company	15/10/2021	Personal

Informal discussions were conducted with researchers who have previously worked in Bihar to understand the challenges that the field throws at a researcher and learn ways to overcome

some of the challenges. These interactions have been an important source of information for me regarding the selection of key respondents. It was during these discussions that potential respondents were discussed and the researchers would give me insights in how to approach these respondents and how best to convince them for an interview. Considering how reluctant people working in the state health society are in talking to researchers, especially from places like JNU; the inputs from these informal discussions were invaluable for me. A study by a team of researchers from Tata Institute of Social Sciences had exposed the sexual exploitation of young girls in correction facilities in Bihar in 2018. I found that the reluctance among respondents who are anyways apprehensive about talking to researchers who they believe would criticize the government, had increased after the TISS episode. The research has adopted purposive sampling technique while selecting key respondents who were taken from three categories, namely, the public sector, private partners and health experts who have worked in Bihar.

Analysis of public-private partnerships at the meso-level (sub-national) is incomplete without putting it in a micro (national) and macro (international) perspectives. The fundamental idea behind PPPs have originated in high-income countries and their origin can be traced to the New Public Management tenets, Washington Consensus recommendations as well as in Reaganomics and Thatcherite policies of the US and the UK. As the intellectual cradle of all these ideas is the neoliberal thought, therefore, this research has neoliberalism as a lens to look at the spread of PPPs in healthcare. Original works of Friedrich Hayek and John M. Keynes were analysed to understand the fundamental philosophy behind neoliberalism. Economists, political scientists, sociologists and public health researchers have all used Hayekian ideas to support and promote PPPs and many of them have used the Keynesian ideas to critique it. However, the selective retention and interpretation by these scholars have somehow muddled the original neoliberal ideas. This is not to say that the ideas have remained static over time and interpretations problematizing or complicating the concepts are unwanted, on the contrary they have the ability to present a more nuanced understanding of an often repeated but improperly understood phenomenon. However, it is equally necessary to always go back to the origin of neoliberal ideas and its elementary doctrines to fully understand how the currently popular imagination of neoliberalism has been shaped by its modern-day advocates.

This research seeks to gain an understanding of how the partnership ideas has evolved to become such a dominant public health strategy, who are the people and institutions behind the

burgeoning growth? This research predominantly uses literature that already exists but its novelty lies in the amalgamation of literature from economics, public health and policy. This is analytical research because a critical approach runs through it, it doesn't try to explain the phenomena of PPPs in healthcare but it attempts to always ask Why. Institutions and individuals from a particular ideological background seem to be enthusiastically promoting PPPs in healthcare, why? Despite having limited to no critical evidence that PPPs are better than other forms of health interventions they are being adopted by governments across the globe, why? So on and so forth. This study would use an interpretivist perspective exploring how the network structures surrounding PPPs interact and influence each other and how the conceptual discourse is disseminated and used at different nodes of such networks.

Causality becomes an obtrusive issue while assessing the assessing the impact of PPPs on health systems. There are multiple factors at play that can lead to changes in a health indicator along with a PPP intervention. These contemporaneous factors or exogenous variables are in multitude and always interacting with each other. Therefore, instead of looking at how a particular PPP intervention causes certain changes in one or more health system indicators, a conscious decision was made to instead look at PPPs as one category of health intervention and its overarching impact on the public health system. Since the implementation of the NRHM in Bihar, there has been no change in the state's policy towards or treatment of PPPs in the health sector. Partnerships have been used across all three levels of the health services; primary, secondary and tertiary and across a varying range of services from ancillary support services like sanitation to actual provisioning of clinical care. Therefore, the idea to treat PPPs as one group of interventions, although heterogeneous seems logical. State Health Society (SHS) and the Infrastructure Development Authority (IDA) are the two nodal bodies for implementing the NRHM/NHM programs and the formation of all public-private partnerships in the state respectively. Plan documents and reports of the two agencies and their reports will be used as primary sources for understanding the state's approach towards forming these partnerships in health.

One challenge that qualitative researchers have to grapple with is how to establish a causal link between the outcome and the input? What if the change in output has happened independently cause by other factors and the input in question has nothing to do with the change! In this thesis, since PPPs are being taken as one group of health intervention and a temporal change in health system indicators is associated with a sustained reliance on PPPs; how can we say with

certainty that public-private partnerships have or have not led to the strengthening of health systems in Bihar? In other words, how valid is the assertion that is to be made. According to research methodology literature, one way is to use multiple methods of data collection and converge the results. For the purpose of this research, data from KII is converged with data representing change is health system indicators and data from other evaluation studies.

To compare the performance of the health system in Bihar on the Six health system building blocks, indicators pertaining to six the building blocks have been compared from 2005 to 2019/20. On a few occasions, lack of availability of date from these specific time periods have forced to use date from a few years before or ahead. The data sets used in this attempt are as follows:

- NFHS 3 (2005-06), 4 (2015-16) and 5 (2019-21).
- NSSO 60th round conducted in 2004 and 75th round of 2018.
- National Health Accounts (NHA) estimates.
- State Economic Survey reports, the first report was published in 2006.

Since literature for the research came from varied themes; economic theory, history and philosophy of economics, political economy, public health, health policy and systems at the global as well as national level; a systematic review was not feasible. However, the ‘citation tracking’ tool used in systematic reviews was more suitable considering the wide range of themes. It helped me to find literature that I would have missed otherwise if I had stuck only to a keyword search strategy. Searching with keywords, was although essential towards the beginning, the results saturated after a point of time and there was no way that the depth of literature needed could be fulfilled with keywords. Citation tracking helped me to traverse the disciplinary boundaries and led to a rich repertoire of literature that analysed PPPs from different vantage points.

Sources of Literature: Primary as well as secondary, both from online and offline sources. Expression of Interest and Terms of Reference documents and reports of the State Health Society of Bihar, Bihar Medical Services and Infrastructure Corporation Limited and the Infrastructure Development Authority of Bihar are the main sources for policy literature and data pertaining to public-private partnership schemes in Bihar.

Document review- Expression of Interest (EoI) and Terms of Reference (ToR) documents give important insights into the processes that are involved in the scoping and selection of partners

by the government. The research will review various plan documents, including the national Program Implementation Plan, the State Program Implementation plans, government reports, and tender documents/advertisements and information obtained from State Health Management Information System (HMIS).

Online Sources: Biomed Central, PLOS and Google Scholar, Websites of Niti Aayog, Registrar General and Census Commissioner of India, Indian Institute of Population Studies, Ministry of Health and Family Welfare (MoHFW), World Health Organization (WHO), United Nations International Children's Emergency Fund (UNICEF), Multilateral Banks (World Bank, IMF and others), Management consultants and Philanthropic institutions.

Referencing Style: This thesis will use the Harvard Style of referencing. The built in 'Citations and Bibliography' command in Microsoft Word has been used for this purpose for generating in-text citations as well as the list of references.

1.5 Structure of this thesis

Chapter II focusses on teasing out the intellectual contestation between the state and the market over their roles in the economy. this context has been ongoing since the propagation of the capitalist economic model. Within the capitalist model itself, these have been disagreements on role of markets and their independence from any state interventions. Hayekian vs Keynesian ideas have come to represent some of the most significant aspects in the history of capitalism. In several ways, Friedrich Hayek may be considered the 'godfather' of modern neoliberalism. The influence of his ideas on neoliberal thought is palpable and he is also credited with starting a kind of intellectual movement or a thought collective that would organize neoliberals in the middle of the 20th century and pave the way for their phenomenal accent. From classic liberalism to neoclassical economics and from Keynesianism to neoliberalism, this chapter attempts to capture how different stands of capitalism have viewed the role of markets. Another important inquiry that this chapter makes is the role of markets in healthcare; there is considerable to prove that healthcare is unlike any other economic commodity and that market mechanisms fail in healthcare if allowed to operate freely. Public-private partnerships, therefore, must be studied in the context of neoliberalism as they embody all these debates and contestations and claim to offer a unique proposition of 'collaboration' rather than dispute between market forces and the state. The next chapter will delve into the details of how credible and effective these claims are.

Chapter III is an exercise in deconstructing public-private partnerships. It defines what 'public' and 'private' mean and argues that these concepts are not static and therefore the task of defining PPPs becomes challenging. After going through the definitions proposed by policy guidelines and scholarly works on PPPs, it deliberates upon what are the strengths and weaknesses of the PPP model in healthcare. It also describes how institutors propagating neoliberal ideas like management consultants, multilateral banks, think tanks and funding institutions have created an aura of positivity around PPPs in healthcare; often devoid of any scientific evidence. The chapter also analyses how the arguments of market efficiency and knowledge superiority of private market players that was used to pare down the role of governments in public services during the 1980s under the umbrella of the New Public Management ideas, resonate so comprehensively with the arguments favouring increased role of PPPs in healthcare. The chapter argues that this is more than a mere coincidence, rather it represents a shift in neoliberal strategy of market expansion in healthcare: from privatization to public-private partnerships. Indian health policy, especially after NRHM has been very welcoming to the increased role of PPPs in the health sector in India. But the proclivity to include the private sector both for-profit and not for profit in providing healthcare has been an important part of India's health strategy long before NRHM. NITI Aayog has emerged as one of the strongest proponents of PPPs in healthcare; as India's apex policy making body their influence on the directions that public health in India is taking is instrumental. As more and more frontiers of partnerships emerge in India, it is therefore necessary to investigate if they are really as affective in improving people's health as the proponents claim.

Chapter IV presents a social, economic, political and demographic picture of the state of Bihar. It analyses how the ideas of PPPs spread at the sub-national level in the state of Bihar and looks at how and when the neoliberal policies were accepted by the state government and what were the reasons for their delayed implementation. Caste dynamics has not only shaped how the state's society is organized but it also shapes the political realm in the state. Caste also decides land ownership in a state whose economy predominantly relies on agriculture and therefore, the production systems in the state and its economics is also determined to a great extent by caste equations. This chapter also looks at the role of NRHM in the implementation of PPPs in the health sector in the state. NRHM brought a sudden and large influx of money in a state whose institutional capacity had withered over years of neglect, making PPPs a natural and perhaps only option to utilize those funds. Other than the national and sub-national determinants that shaped the PPP landscape in the state, the role of global factors, especially

that of international finance institutions cannot be undermined. Through their funding programs, they have influenced the state's health sector and its amiability towards accepting PPPs as a viable and long-term strategy for the state.

Chapter V: This chapter explains how the health sector in Bihar, both public and private, is organized. The constitution of the private and the public in the state shapes the character of partnerships in the state. The diagnostic services partnership was the first PPP implemented in the state in the post-NRHM phase and the entire process; from its inception to its falling into a state of chaos is a representation of the major issues that are still a part of the PPP model in the state. The chapter also contains an analysis of the in-depth interviews conducted with the key informants to identify some of the dominant themes that come up when one studies the growth of PPPs in the state and attempts to understand why is it in the present form as it is. It tries to answer why partnerships seldom continue in Bihar after the end of the first tenure; how are partners chosen, how partners view themselves in these arrangements and what are their grievances from the state and so on. It analyses some of the presently ongoing partnerships in the state as well as a few of the partnerships from the past to see if the 'failures' have provided any learning experience. It also describes how the public health system and its administration is organized in the state.

Chapter VI The change in indicators pertaining to the six building blocks of the health system in Bihar has been analysed in this chapter. The selection of particular indicator/s has been done according to the availability of data. The goal is to check how have the building blocks of the health system changed from 2005 until now; how they become more robust or weaker or there has not a significant change. Monitoring and evaluation reports from some of the government agencies like the Comptroller and Auditor General of India (CAG), Common Review Mission (CRM) reports of the National Health Mission (NHM) have observed that PPPs don't strengthen the health system; the same has also been affirmed by the respondents during the interviews. A few independent reports and articles have also argued that PPPs are implemented at the cost of health system strengthening. The evidence from multiple sources is coalesced in this chapter to arrive at a conclusion on the impact of PPPs on the health system in Bihar.

Chapter II- Neoliberalism: History, Present form and the State vs Market debate

> "Self-identified neoliberals are hard to come by; there is no political party or national regime that touts the 'neoliberal' moniker; it does not denote a professional position in economics or anywhere else. And yet many take the view that neoliberalism's continued reign is among the most perplexing puzzles of our time" (Mudge in Mirowski, 2014, p. 6)

Neoliberalism has for the most part in its history has been used as a pejorative term used against globalized capitalism. So much so that the instances of someone identifying oneself or some group identifying itself as neoliberal has been rare. The term was coined at the Colloque Walter Lippmann or the Walter Lippman Colloquium in 1938 to distinguish it from the traditional liberal thought (Horn & Mirowski, 2009). The purpose of the Colloque Walter Lippman was to declare their support to the laissez faire model of organizing the society and revitalize liberalism rejecting collectivist and socialist values. The colloquium was named after Walter Lippman, who was a famous American journalist and a public intellectual and because of his popularity was regarded as the most important figure in the liberal networks at the end of the 1930s (Colin-Jaeger, 2021). The term neoliberalism was also briefly used by Milton Friedman in an essay titled 'Neo-Liberalism and its Prospects' presented at the Colloquium in 1951 (Peters, 2021). Use of the term neoliberal/neoliberalism fell completely out of favour amongst its followers in the subsequent decades until very recently. Adam Smith Institute attempted to salvage the term from the relative ignominy it has suffered in one of their posts on their websites in 2016 titled 'Coming out as neoliberals'; the think tank rued that proponent have disowned the term.

> "And then, of course, is the fact that 'neoliberal' is already in use today, but almost exclusively as a slur. For a large number of people (mostly on the left), neoliberalism describes the modern world order and the fact that nobody self-describes as a neoliberal is proof that nobody is willing to defend that order. Well, not anymore." (Bowman, 2016, p. 1)

They go on to explain that a neoliberal is someone who is pro-markets and economic growth, advocates individualism and individual property rights, is open-minded and practical, has a globalist outlook of the world and is optimistic about the future believing that the world is changing for better (Ibid).

It also claimed that "massive reductions in poverty across the developing world and rise in wealth in places like China and India are thanks to the neoliberal order" (Ibid, p.2). It also credited the 'Washington Consensus' Policies for bringing some much-needed fiscal discipline to these countries. The 'Washington Consensus' was a term introduced by John Williamson to describe A set of ten policy recommendations given by three Washington, D.C. based institutions, the United States Treasury, the International Monetary Fund, and the World Bank in 1989 to their debtor countries so that they overcome the financial hardship they were facing. These were; reduce budget deficit, tax reforms, low public subsidies, liberalization of financial sector, adopting free floating exchange rate policy, adoption of free trade policies, relaxing barriers to foreign direct investment, privatization of state enterprises, deregulation of markets and secure property rights (Williamson, 1993). However, despite the audacious clarion call, the followers of the neoliberal thought have preferred to remain 'unnamed'.

2.1 Defining Neoliberalism:

The phrase 'neoliberalism' is made up of two words: neo, which means new, and liberal, which means free of government intrusion. Liberalism arose from Adam Smith's work in the mid-1770s, when he argued for the government to play a minimum role in economic concerns so that trade may flourish (Davies, 2014). Liberal economics reigned the world for nearly 200 years before being temporarily displaced in the 1930s by Keynesian economics, which argued that government involvement was necessary to keep the economy in a balanced state. Liberalism, or the demand for deregulation, privatisation, and the elimination of government intervention in the market economy, returned with a vengeance in the 1970s, earning the moniker "renewed liberalism" or "neoliberalism" (Horton, 2007, p. 1).

Under Keynesian welfarism the state provisioning of public goods and services was considered as means not only to ensure social well-being but also to reinvigorate the economy by contributing to the supply side factors (Gordon, 1991). However; neoliberalism preferred a minimalist state and opted for supply side interventions like interest rate manipulation to control the economy. Gordon also argues that Neoliberalism in its most rudimentary form is an absolute challenge to the philosophy underpinning the welfare state (Ibid).

Neoliberalism broadly refers to the widespread restructuring that has happened in the global economies since the 1970s in the name of a 'post-welfare state' model that embraces and propagates unrestricted markets as the most effective means towards the goal of achieving

economic growth and public welfare. Although Thatcherism in the United Kingdom and Reaganism in the United States are sometimes cited as prototypes of neoliberalism, policies based on a similar market-centric logic have been implemented in variegated forms in a number of countries (Bell & Green, 2016). It was also exported to the Global South as a result of the World Bank's and the International Monetary Fund's Structural Adjustment Programs and fiscal austerity initiatives. Neoliberalism has been the dominant economic and political philosophy among global institutions and governments since the 1970s and presently it seems to be everywhere (Barnett & Bagshaw, 2020). However, it would be a mistake to assume that it had its origins during that time. An economic philosophy which is also referred to by several authors as 'market fundamentalism' or 'market orthodoxy' or 'free-market economic theory' and many more monikers began to take its now recognizable formidable form in the 1940s.

Neoliberalism is interested in limited government roles and interventions in relation to markets; it believes in the efficiency of the free market and prioritizes policies like deregulation, fiscal deficit reduction, privatization of the public sector, individualism and marginalization of welfarism (Hancock, 1999). Navarro uses the term neoliberal orthodoxy to define Neoliberalism; state and its interventions as obstacles in the path to economic prosperity and also social development (Navarro, 1998). Characteristics of the neoliberal orthodoxy are:

- Budget deficits are bad
- State's regulation of the labour market is bad
- Social protection and other redistributive policies hinder economic growth
- State shouldn't intervene in foreign trade or international financial markets.

The unfettered functioning of market forces forms the core of neoliberalism's theoretical assumptions; it potentially leads to greater resource utilisation and allocation, ensures better satisfaction of consumption needs and a larger balance of international trade, and hence leads to stronger economic growth and development. The state's minimal responsibility is to ensure that the market economy's laws are respected and that the market can function effectively. Neoliberalism argues that extending the reach and frequency of market transactions will increase the social benefit, and it strives to bring all human activities under the purview of the market (Harvey, 2005).

The goal of neoliberalism is to replace political judgement with economic evaluation; social, political and cultural values are endangered by the power of cost-benefit analysis. As a result,

neoliberalism can be characterised as the elevation of market-based concepts and evaluation methodologies to the level of state-endorsed standards (Davies, 2014). According to David Harvey, one of the worst leading scholars on neoliberalism; it is a political economic theory, which prescribes that the best way to achieve and improve human well-being is by liberating the individual spirit of entrepreneurship within an institutional framework that is characterised by free markets, free trade and strong private property rights (Harvey, 2005).. As far as the role of the state is concerned, it should limit itself to the establishment and maintenance institutional structures that are favourable to such individualized behaviours (Ibid). The state should also create the necessary legal and security institutions and frameworks to protect private property rights and freedom to do business. Furthermore, if markets do not exist in some of the traditionally state dominated sectors such as land, water, education, health etc., they must be developed, maybe by government intervention (Ibid). Vivien Schmidt also agrees that although neoliberalism encompasses several normative and policy applications but more than anything else, it is a political economic philosophy (Schmidt, 2016). A neoliberal state should have a restricted political economic role, such as the creation and preservation of a stable institutional framework, which will ensure and protect free markets and will promote free trade and commerce (Ibid).

Neoliberal proponents argue that the underprivileged people in society should find on their own remedies to their lack of health care, education, and social security. If they fail to do so, they are criticized for being lazy and irresponsible citizens (McGregor, 2001). Stephanie Lee Mudge defines neoliberalism as an ideological system that regards the 'market' as a sacred institution, born within the 'human' or social sciences and honed in a network of Anglo-American-centric knowledge producers, and represented in various ways inside post-war nation-state institutions and political spheres (Mudge, 2008). It has also been argued that neoliberalism is rooted as much as in a moral project than a political and economic project, it articulates itself in the language of economics, that praises the moral benefits that a market society offers, recognising that markets are a prerequisite for human freedom in other aspects of an individual's life (Fourcade & Healy, 2007). **In all its myriad forms and strands, neoliberalism is built on a single, fundamental principle: the supremacy of individualized, market-based competition over other means of state-market organization, this basic principle is the hallmark of neoliberal thought** (Mudge, 2008). In comparison to other forms of economic liberalism, neoliberalism is distinguished by its desire to 'liberate' the market and elevate it to a level above politics; that is, to free it from all forms of political intrusion.

The word 'neoliberalism' has become increasingly well-known in recent years. Until the 1990s, it was relatively lesser known, popularised only by its critics as a free-market orthodoxy spreading around the world under the aegis of the 'Washington Consensus'. It was used in a rather derogatory manner as a sort of market fundamentalism, which was pushed on developing countries by Western countries and multilateral agencies. The fundamental premise was that it originated with the rise of Margaret Thatcher and Ronald Reagan in the late 1970s and early 1980s in the UK and US. However, scholarly studies on the longer history of neoliberal ideas prior to that political shift was scarce at the time (Davies, 2014). One thing that neoliberalism has unequivocally achieved is shift the global political economic narrative from the question of 'how much state' to 'how much market' (Mudge, 2008, p. 724).

2.1 Classical Liberalism to Neoliberalism: How similar and how different

Classical liberalism draws most of its ideas from the works of Scottish political economist and philosopher Adam Smith and his beliefs on the functions of the markets and the role of the government. Smith believed that people followed their own self-interest and in the pursuit of self-interest they are 'led by an invisible hand' that not only rewards them individually bit also leads to collective benefits to the society. Adam Smith described free markets as 'an obvious and simple system of natural liberty' (Viner, 1927, p. 198). Adam Smith proposed the idea of a unified natural order, which would operate according to natural law and not powers of institutions of men like governments. Left to run on its own course, this natural order will bring the most benefit to mankind. Smith believed that the natural law was as applicable to economic processes like trade and private property as it was to personal liberty (Viner, 1927). In his celebrated book 'Wealth of Nations', he wrote,

> "Projectors[1] disturb nature in the course of her human affairs, and it requires no more than to leave her alone…that she may establish her own designs. Little else is required to carry a state to the highest degree of affluence…but peace, easy taxes and a tolerable administration. All the rest being brought about by the natural order of things". (Ibid, p 200)

Smith's advocacy for a free market as a natural state of being should be seen in conjunction with an exception that he made in the same book. He mentions a group of upper-class

[1] Prodigals, Imprudent risk takers, and Projectors are the three types of individuals who constitute the rich upper class and have access to bank credit and loans, which they use to interfere with the free and fair operation of the market, manipulating it in order to add to their own wealth.

individuals; Prodigals, Imprudent risk takers, and Projectors can endanger the society and the invisible hand of the market could not deal with them effectively (Brady, 2018). The solution, according to Smith, was for the state or the central bank to ensure any form of credit or loan is stopped to this group of individuals, reducing their power to influence the market as they will not risk their own wealth in an effort to manipulate the market. Smith believed that these people are the real enemies of the state and therefore laws must be passed so that they don't have access to public money and impose their destructive behaviour on the rest of the society (Ibid). However, French Physiocrats took the phrase 'leave her alone' and its French translation has been immortalized as a pseudonym for classical liberalism known as ***Laissez Faire***. (Viner, 1927)

It is important to understand the link between Laissez-faire or classical liberalism and neoliberalism and also know how the two are different. Laissez-faire places an utmost importance in securing the natural right of an individual to accumulate property and engage in commerce, it envisages markets as a self-regulating natural reality whose capacity is hindered and diminished. Therefore, active state intervention in a liberal economy is unwarranted and potentially harmful. Classical liberal discourse is set in the binaries of state versus market, freedom against constraints and flexibility versus rigidity (Bourdieu & Wacquant, 2001).

On the contrary, neoliberalism cannot be reduced to a simple binary of detaching state from the market. The state under neoliberalism is responsible to maintain order so that market grows and thrives. Although it refrains itself from interfering in economic activities but it like Hayek had said, it has to ensure that competitive forces are not throttled. A neoliberal state is, therefore, not a weak and inactive state of classical liberalism but it is a state that establishes and preserves, through its constant action a competitive market order which is an artificial human creation and not a product of nature (Hayek, 1960). The conditions for neoliberalism's success must be actively created unlike under classical liberalism where it comes 'naturally' (Horn & Mirowski, 2009).

2.2 Roots of Neoliberalism-State vs. Free Markets: A Chronological History

2.2.1 Influence of Hayekian thought

The ideological battle over who should have the control over economic activities; governments or markets, has been ongoing for more than a century now. However, the most consequential ideological duel that led to type of world economy that exists today happened not between pro-

market and pro-government thinkers, or socialists vs capitalists, but between two economists who vehemently disagreed over the extent to which markets can be allowed to be 'free'. William Hayek, an economist from the Austrian school was the most influential advocate of the complete freedom of markets from any type of government control. His book titled "The Road to Serfdom" published in 1944 became the most significant philosophical foundation for the free-market ideology.

Hayek's ideology was essentially rooted in the supremacy of individualism. He argued that 'men should be free to develop their own individual gifts and bents' and that it is their god given right. Individualism according to him had led the Western Civilization out of the Middle Ages and to enlightenment. The growth of scientific knowledge that led to the industrial revolution was made possible because of the 'unchaining of individual energies. Individual freedom is the spontaneous force that drives a free society towards achieving greater degree of material comfort and security. However, the material achievements of the free individualist society were taken for granted, "regarded as a secure and imperishable possession, acquired once and for all", slowing the rate of progress and the "principles which had made this progress possible, came to be regarded as obstacles to speedier progres'' (Hayek, 2001, pp. 34-35).

Hayek argued that the idea of a state controlled, centrally planned economy was against the spirit of a free society. Even though it is able to deliver immediate economic results, it will eventually lead to an autocratic state, as Germany and Russia did at that time. However, Hayek did not argue for the state to be completely separated from all economic activities. The role of the state should be limited to ensuring that the spirit of competition is encouraged and protected by the state.

> "The liberal argument does not advocate leaving things just as they are; it favours making the best possible use of the forces of competition as a means of coordinating human efforts. It is based on the conviction that, where effective competition can be created, it is a better way of guiding individual efforts than any other. It emphasizes that in order to make competition work beneficially a carefully thought-out legal framework is required, and that neither the past nor the existing legal rules are free from grave defects…the successful use of competition does not preclude some type of government interference" (Hayek, 2001, p. 37)

Even Hayek was also aware that there are some limits to the overarching power of competition. He argued that public goods and services cannot be left entirely to be provisioned by the market forces as there are chances of what is later defined by economists as ‘market failure’.

> “To create conditions in which competition will be as effective as possible, to prevent fraud and deception, to break up monopolies- these tasks provide a wide and unquestioned field for state activity” (Hayek, 2001, p. 38).

> “The successful use of competition does not preclude some types of government interference…instance, to limit working hours, to require certain sanitary arrangements, to provide an extensive system of social services is fully compatible with the preservation of competition…There are, too, certain fields where the system of competition is impracticable. For example, the harmful effects of deforestation or of the smoke of factories cannot be confined to the owner of the property in question” (Ibid).

Hayek’s arguments in favour of the free-market economic system continue to guide neoliberals across the world. Several economic think tanks on the global stage follow the Hayekian philosophy, designated ‘chairs’ have been established in some of the world’s most influential universities in his name and his disciples, one in particular, Milton Friedman became the strongest disseminators of the neoliberal policies. However, for a significant part of the 20th century, Hayekian economic thought remained on the margins of the economic thought. There was an attempt to bring the neoliberal ideas to the mainstream by some intellectuals but they did not gain the desired popularity. Several of the participants of The Walter Lippmann Colloquium of 1938, including Friedrich von Hayek and Ludwig von Mises went on to make a more concerted and large-scale effort to organize the neoliberal intellectuals nine years later. It should be kept in mind that aside from debating over the dangers of a collectivist and interventionist state as well as the weak state of liberalism, the participants at the Colloquium debated over the tenets as well as the designation of a renewed liberalism, agreeing upon the term ‘neoliberalism’ (Bernhard Walpen in Mirowski and Plehwe, 2009 p.13). In the year 1947, a network of organized neoliberal intellectuals brought together by Hayek and Ludwig von Mises, invited a group of people including philosophers, economists and a few rich businessmen to Mont Pelerin in Switzerland in the year 1947 (Plehwe, 2009). The organization that took form was called the Mont Pelerin Society (MPS) (Ibid). The founders and early members of MPS, unlike other intellectuals in the 1950s, did not see universities or academic

mobilisation as appropriate primary means for achieving their goals. Early neoliberals believed they were shut out of the majority of high-profile intellectual forums and knowledge centres in the West. As a result, the MPS was established as a secret members-only debate organisation whose members were hand-picked and who purposefully avoided public scrutiny (Mirowski, 2009). They avowed to support the creation of a network of think tanks to establish neoliberal ideas, pioneering what is referred by economic historians as the 'neoliberal thought collective' (Ibid).

> "The various groups of neoliberals that joined the MPS from different countries and professional backgrounds were driven by the desire to learn how to effectively oppose what they summarily described as collectivism and socialism, and to develop an agenda diverging from classical liberalism. Scholars from different disciplines shared their expertise and debated with a select group of journalists, corporate leaders, and politicians, as well as a new breed of knowledge professionals (operating out of the rapidly proliferating neoliberal partisan think tanks)" (Plehwe, 2009, p. 9).

Other than Hayek and Mises, some of the famous neoliberal thinkers who were MPS's members are Nobel prize winners Milton Friedman, Gary Becker, Ronald Coase and James Buchman. Nine of its members have won the Nobel Prize in economic till date. For a significant part of its history, the MPS has chosen to work rather anonymously but that doesn't by any means reduce its pioneering contribution towards propagating the neoliberal ideology.

It was not until the economic crisis of 1970s that his ideas gained widespread acceptance in western economies. It was a British mathematician and economist John M. Keynes whose ideas very nearly ruled the political-economic landscape of post-World War II economies in Europe, Asia and North America. Keynes's economic tenets were instrumental in the tremendous economic growth that the global economy underwent from the 1950s until 1970s. His book titled "The General Theory of Employment, Interest and Money' that was published in 1936 guided two of the three Allied economies during and after the second world war. Although Keynes had claimed on occasions to be a socialist, his writings and policy prescriptions state otherwise. He never advocated for a fully state-controlled economy, rather his economic thought pivoted around finding the reasons of a market failure and the ways to avoid or correct it. He was a strong proponent of some of the tenets of a socialist economy though, like central planning and anti-free market beliefs (Henry, 2010).

2.2.2 Keynesian Capitalism: Saving Capitalism from the market

The post-industrialization world economy witnessed unprecedented growth, driven by technological advancements the market economy and the capitalist economic system was adopted by the dominant global economies until the beginning of the 20th century. Stricken by the great economic depression and enduring the travails of the first world war, these countries began to look for alternative away from the capitalist economic system.

British economy took a different path towards the great economic depression than its American counterpart. It was the first industrialized economy of the world and maintained its dominance over world trade until the spread of the revolution to other countries in Europe, Asia and America. British exports dwindled as its monopoly over industrialized production ended (Elbaum & Lazonick, 1984). As a result, its economy was already stressed even before the first world war and it did not experience the same economic euphoria that the US did in the early 1900s. It was also reeling under a huge unemployment burden after the end of the world war. The war-ravaged economy could not provide employment to several thousand war returnees. It was clear to the economists, that unemployment had brought the market-economy model to its doom as the existing neo-classical economic theories could neither explain the global downturn of capitalist economies nor they had any remedies for that. John M. Keynes was the advisor to the British government during the first world war, and went on to join the British peace delegation at Versailles (Yergin & Stanislaw, 2002). Keynes was at the helm of the British economic policy between the two world wars. Like his peers, he was also perplexed by these regular downward turns that capitalist economies witnessed almost cyclically. However, his analysis of the problem was unlike any of his peers. It was so novel analysis that revolutionized the contemporary economic thought effectively laying the foundation of the whole new strand of economics known as 'macroeconomics' (Wapshot, 2012).

Keynes was not a believer of the laissez-faire policy and contested the idea of markets as organic self-correcting entities. Keynesian economic policies became a dominant force in the global political economy landscape through the mid-20th century. Especially after the publication of Keynes seminal treatise 'The General Theory of Employment, Interest and Money' in 1936. The book was widely well-received by economists and laid the foundation of a new school of economic thought known as Keynesianism. The book argued against the neo classical understanding that any time the market is out of the state of equilibrium, the movement of price will restore the balance through altering supply and demand. In terms of national

income and public/private investments in the economy, according to this understanding, market forces had the ability to self-correct through the increasing/decreasing of interest rates. In case of an increase in income or savings, the interest rates would also increase so that people would invest more and vice-versa. However, Keynes contradicted this idea arguing that

> "The influence of this factor (interest rate) on the rate of spending out of a given income is open to a good deal of doubt…The usual type of short-period fluctuation in the rate of interest is not likely, however, to have much direct influence on spending… there are not many people who will alter their way of living because the rate of interest has fallen from 5 to 4 per cent, if their aggregate income is the same as before" (Keynes, 1936, pp. 50-51)

Keynes central argument in the General Theory was that the idea of market induced equilibrium is not true in specific cases but cannot be applied to the 'general case' meaning the larger macroeconomic cases of national income and expenditure (Ibid). He also argued that the equilibrium theory was based on the assumption that a large number of variables were constant including employment and this could lead to 'misleading and disastrous' consequences. Keynes made employment a dependent variable that was a function of investment. Investment was at the core of the general theory; it asserted that increase in investments has a 'multiplier effect' on savings/income (Samuelson, 1964). Investment had the potential to increase the national income by a factor of one or more, i.e., the national income would increase at least by the amount of increased investment. General Theory's novelty and widespread popularity stemmed from its unique proposition that any amount of unemployment can be overcome by increasing public/private investments in an economy (Skidelsky, 2010).

Keynesian ideas had also had a determining impact on another contemporary British economist, William Beveridge, whose eponymous report in 1944 laid the foundation of the modern 'Welfare State'. Three major areas that warranted state's responsibility according to the report were comprehensive healthcare, full employment and family allowances. The Beveridge Report proposed a comprehensive system of social insurance popularly known as 'from cradle to grave' social program, which would ensure healthcare to the sick, the retired and the widowed and the unemployed by the means of a weekly premium borne by the state (Abel-Smith, 1992). The National Insurance Act was also passed in 1946 that established an insurance system contributed by the government, private employers as well as the employees, to protect the beneficiaries against illness and maternity expenses and also provided pension

and unemployment benefits (Ibid). However, arguably the most important initiate that became a benchmark for health systems all over the world, was the establishment of the National Health Service (NHS). For the first time, the National Health Service Act put in place a universal healthcare service in the United Kingdom wholly provided by the state. NHS had provisions for free diagnosis as well as treatment of health conditions in a health facility as well as at people's homes; dental and ophthalmic care that were traditionally excluded in private insurance cover was also included in the NHS (Gorsky, 2008). Beveridge wanted to ensure for all British citizens, a minimum standard of living. The Beveridge's lineage is still well-entrenched in social and economic policy debates around the world for its ability to permeate socialist values in a capitalist economy (Whiteside, 2014).

2.2.3 Neoliberalism supplants Keynesianism

Although Hayek formulated neoliberalism's core beliefs before WWII, Keynesian economics, which emphasized on increased government involvement in and regulation of private markets, dominated the post-war reconstruction phase and continued to do so for almost three decades. Countries involved in or affected by the war had their economic planning and administration led completely by the state. The dominance of neoliberalism in political decision making and economic policies did not emerge until the beginning of 1970s. This was a decade marked by escalating economic downturns and oil price shocks that tripled the cost of capitalism's primary energy supply (UNDESA, 2017). In 1971, the United States permanently delinked the US dollar from the gold standard in order to help pay off its Vietnam War obligations and revitalise its domestic economy. This threw financial markets into disarray, currency speculation became a money-making mechanism and the US dollar was cemented as the world's 'reserve currency', held in reserve by other governments and financial institutions so that they could pay off international debt and stabilise the value of respective currencies when needed (Ibid). Two years later, the 1973 military coup in Chile provided the first experimental laboratory for Hayek and Friedman's neoliberal economic pupils. Margaret Thatcher of Britain, Ronald Reagan of America, and Helmut Kohl of Germany soon joined the Chilean Augusto Pinochet in promoting neoliberalism.

The decade of 1970s was monumental in the history of global capitalism. Its expansion was fettered by the consolidation of the working class across the world, a healthcare system that was funded, controlled and often provisioned by the state was in favour, most economies had a progressive tax regime and Keynesian economic policies had marginalized the free-market

discourse. It was a decade of Alma Ata and the formation of a global consensus that health for all will be achieved by ensuring universal primary healthcare. It was also the decade when the neoliberals mounted their strongest onslaught on the anti-free market ideology. The neoliberal attack was unlike any other forms of capitalist push-back against state intervention. One of the most distinguishing features was the way in which the neoliberal though organized itself. Finding it difficult to stand its ground in universities and academic spaces that were dominated by the Keynesian thought; neoliberals took the alternative route of think tanks, consultancies, intellectual societies, philanthropic institutions and industry bodies or confederations. Multilateral organizations like the Bretton woods institutions and the WTO joined the collective subsequently.

In an essay that was published in the University of Chicago Law review in 1949, Friedrich Hayek had presented a strategic blueprint of turning the popular intellectual opinion in their favour. He had distinguished groups like journalists, film makers, writers, school teachers from "scholars or experts in a particular field" calling them "second hand dealers in ideas" (Mitchell, 2009, p. 386). These are the groups that control the distribution of expert knowledge amongst ordinary members of the population. Therefore, the job of the neoliberal movement was to design a network of influential individuals and institutions who would lead the distribution of neoliberal ideas among these second-hand dealers and that is how neoliberalism would try to change the world (Ibid).

2.2.4 'Second-hand dealers' of Neoliberalism

Think tanks perhaps played the most important role as the 'dealers' of neoliberal ideas if one looks back at the history of neoliberal thought. Backed with the copious funds from corporations, mostly under the guise of private foundations, these think tanks re-packaged neoliberal doctrine for easy dissemination and consumption among general public. Antony Fisher, an English businessman who was greatly influenced by the ideas of Hayek's Road to Serfdom, asked for Hayek's on his idea of joining politics to further the cause of free market and trade. However, Hayek advised him against going into politics, instead he recommended that Fisher should establish a public policy think tank.

> *"Fisher: I share all your worries and concerns as expressed in The Road to Serfdom and I'm going to go into politics and put it all right".*

> *"Hayek: No, you're not! Society's course will be changed only by a change in ideas. First you must reach the intellectuals, the teachers and writers, with reasoned argument. It will be their influence on society which will prevail, and the politicians will follow".* (Hayek, 2001, p. 20)

This is how the foundations of the Institute of Economic Affairs (IEA), a think tank that played a crucial role in making the Thatcherite British dream a reality, was laid. Fisher would go on to become a driving force behind the formation of free-market groups, connecting the IEA to new and existing organisations around the world. Fisher also went on to establish a larger network of academic and development institutions around another one of the think tanks that he founded in 1981 called the Atlas Economic Research Foundation. The foundation's network spreads across 100 countries and its operations in South Asia were started rather late in 2021. Think tanks have helped in building the philosophical and the academic reasoning behind neoliberal policies for decades now (Cahill, et al., 2018). Management consultants have similarly contributed to the groundwork in operationalizing these ideas through the tenets of output and profitability. Consultants also contributed immensely in the neoliberal collective first by extolling the virtues of private economy but then mostly by propagating the ideas of New Public Management. In the 1980s, New Public Management (NPM) reforms were introduced as a response to Keynesianism, it founded on the belief that private-sector management approaches were vastly better than the bureaucratic principles of public administration.[2] BCG was the first consultancy firm to be founded in 1964, Bain and Company was established in 1973 and Price Waterhouse World Firm was formed in 1982. Deloitte & Touche was already in operation for several years now and was diversifying to newer business segments. Consultants and advisers, drawn predominantly from the large accountancy and management consultancy firms, have played a key role in the privatization of previously nationalized assets and the implementation of the neoliberal agenda (Jupe & Funnell, 2015). Their advisory role was rarely technical, as it was publicly stated, it was rather intertwined with economic and public policy decisions (Ibid).

2.3 Distilling the key tenets of neoliberalism:

Hayek's thought is widely recognized to have played a key role in inspiring and coordinating the economic, political and intellectual project. It must be remembered that many of the

[2] An in-depth analysis of NPM principles has been done in the next chapter.

Hayekian ideas of a liberal society do not conform to the now popular neoliberal tenets. It has managed to achieve a number of significant political and economic policy victories since the late 1970s, which has resulted in the development of a nearly coherent paradigm that spread across different countries of the world in the subsequent decades. Although several tenets of global capitalism are assimilated in the neoliberal thought, there are some fundamental differences that make it stand out from all its predecessors. The list below puts together some of the major characteristics of neoliberal thought defined by prominent thinkers:

- Capital has a natural right to move freely across national boundaries. Labour on the other hand does not enjoy a similar freedom.
- State's interventionism in economic and several social activities must be restricted.
- Deregulation of labour and financial markets so that the enormous creative energy of the markets is released for everyone to benifit.
- Competition in a well-functioning market needs and it is the only area that needs states intervention if conditions favouring a competitive market doesn't exist.
- Budget deficits are detrimental to economic wellbeing
- Social protection and redistributive schemes hinder economic growth
- Inequality is not an unintended by-product of market, rather it is a necessary characteristic of market that stimulates growth.
- Markets can always provide solutions to problems, even those caused by the market in the first place.
- Ethics, morality, and social values are the responsibility of each individual, not the state or private sector. People also do not care about the social conditions of production and employment under neoliberalism, but they respect private property and obtain their own identity through private spending (McGregor, 2001).

Despite the fact that almost every neoliberal thinker has identified the state as the key problem, most have also recognised the need for a strong state capable of establishing the institutions required to support a free market. The fundamental contradiction in neoliberal thinking is that, while neoliberal principles demand a severely limited state, neoliberal practise necessitates a strong state capable of enforcing neoliberal reform. As a result, rather than producing a fully neoliberal state, neoliberalism has developed a considerably more interventionist state that is compatible with basic neoliberal ideals and is amiable to implement the policies and programmes that those principles demand. The goal of the neoliberal project has not been the

complete enervation or destruction of the state, rather it has been to redefine its functions and limit its authority.

2.3.1 The detriments of 'free-market'

It is interesting to see that both Adam Smith and Fredrick Hayek do not actually believe in a completely 'free market' and have laid down conditions where the interventions from the state is necessary to save market from market forces themselves. Keynes also underlined similar beliefs in General Theory and said that actions of 'Speculators' who work through institutions like the 'Wall Street', can't be claimed to be part of laissez faire capitalism, they rather serve their own self-interest by manipulate the market (Keynes, 1936). The now popular debates around free markets trace their origins to the ideas of Milton Friedman who has been the undisputed poster boy of neoliberalism. Friedman at his prime was no longer an economist, he was a celebrity, he was a regular on television talk shows popularising his ideas in layman language, he had made a ten-part documentary series titled 'Free to Choose' that was aired on PBS channel, he was considered to be very close to two American Presidents and he was given a Nobel Prize (Sorkin, 2020). Friedman contested the classical idea that individual freedom is paramount and sacrosanct and collectively it will lead to social welfare. He pondered if personal freedom begets market freedom or is it the free markets that bring personal freedom and argued that although intuitively it would seem that individual freedom would lead to free markets, in reality 'free markets make free men and not the other way around'. (Friedman, 1974). His formal debut as a free-market crusader happened in his own trademark flamboyant style when he co-published and distributed pamphlets titled "Roofs or Ceilings: The Current Housing Problem" in Chicago in 1946. He argued that rent control should be removed as it was slowing down the local economy, government and the factory owners were not raising wages because of that and if deregulated, inflation will be under control as the "extra income received by landlords would be offset by the decrease in the funds available to tenants for the purchase of other goods and services" (Friedman & Stigler, 1946). Friedman's seminal book from the Chicago School titled *Capitalism and Freedom* has been termed as a 'corporate neoliberal version of Road to Serfdom' (Horn & Mirowski, 2009). Going places where even Hayek hadn't been, Friedman made recommendations that ruthlessly called for more powerful and freer markets and blamed governments whenever markets failed (Friedman & Friedman, 1962). He proposed that the corporate income tax should be abolished, advocated for 'health through choice' model and for 'denationalizing' and privatizing of schools. He also argued that corporations should not be expected to be socially and politically responsible. Using the

metaphor of a ‘game’, he argues that as every player is expected to play fairly in a game but there are always a few who don’t and that is why a set of rules and an umpire is needed, similarly in economics, the government has to become that umpire, intervening only when a player/s refuse to obey the rules. In this way, “What the market does is to reduce greatly the range of issues that must be decided through political means, and thereby to minimize the extent to which government need participate directly in the game.” (Ibid p. 21).

Any form of state’s intervention or regulation of economic activity in the market is opposed in the neoliberal agenda as it would disrupt the operation of ‘the invisible hand’, which is capable to align the production, consumption, and distribution activities most efficiently. They argue that market disparities are a natural by-product of a well-functioning economy, and that the market rewards people based on the amount of money they put into the market. A core principle of neoliberalism is that citizens are to be defined first and foremost as consumers. This idea originates from classical liberal theory that in a market, consumers have all the necessary information to act rationally in their own interests. This is the reason why neoliberal governments and policy influencers advocate that availability of ‘consumer choice’ in sectors like health and education. However, this advocacy ignores the fact that services like health and education doesn’t follow the classical demand and supply model and also consumers don’t possess sufficient knowledge about these services to make an informed decision. Defining people simply as consumers makes it so convenient for neoliberals, then one does not have to worry about inequality and redistributive justice. Critical to the idea of ‘consumer choice’ is that, in exercising their rational decisions, consumers are fully aware of the all options available. In case of healthcare, it is apparent how most often, a patient is not in a position to make an informed rational choice. However, in case of healthcare, all these economic ideas fail to govern consumer choice.

State interventions or regulations are not only ineffective and distortive, but they are also unethical (Coburn, 2000). In fact, some traditional neoliberal economic theorists have written that inequality is necessary for economic growth as it incentivises increased investments (Friedman, 2006). Benjamin Friedman also argues that economic growth will eventually lead to people or groups at the top to voluntarily share the benefits of the economic system with everyone else (ibid). The subsequent section will show in greater detail how healthcare in so many ways, is unlike any other economic commodity and rules of the market have time and again failed to explain its movements.

For a number of decades, neoliberal economists underplayed the significance of the rising economic inequality concomitant with the rise in free markets. Simon Kuznetz paper titled 'Economic growth and income inequality' that was published in 1955 went on to provide the academic grounds for the spread of this belief. Kuznetz argued that as economies grew, inequality would grow simultaneously but it will peak and stabilize and then begin to decrease. This 'U-shaped' trajectory of economic growth also became the bedrock of the 'trickle-down effect' and was enthusiastically cited by development banks for a number of years. A world bank report of 1976 authored by Montek Singh Ahluwalia[3] proposed that accelerated economic growth was sufficient to improve the living conditions of all strata as income inequality follows a U-shape; "inequality increases substantially in the early stages of development, with a reversal of this tendency in the later stages" (Ahluwalia, 1976).

However, more than half a century later there is no sign of the 'trickle-down effect' and there is more or less a consensus that the neoliberal policies lead to economic inequality. To the extent that even the IMF recognized in one of its reports of 2016 that increased inequality is one of the 'prominent costs' of neoliberal agenda and attention must be paid to the distributional aspects of the neoliberal policies (Ostry, et al., 2016). Nobel Prize winning economist Joseph Stiglitz has argued that markets, by themselves, even when they are functioning harmoniously, often produce high levels of inequality (Stiglitz, 2016). Thomas Picketty in his book "Capital in the 21st Century" has also questioned the credibility of the Kuznetz Curve.

"Nevertheless, the magical Kuznets curve theory was formulated in large part for the wrong reasons, and its empirical underpinnings were extremely fragile." (Picketty, 2013, p. 15)

2.4 Neoliberal Healthcare:

2.4.1 Is healthcare a demand-supply problem?

Health, in a neoliberal framework is like any other economic commodity that is governed by the ruled of demand and supply. Neoliberal healthcare model does not recognize healthcare as a basic human right of individuals and considers state's interventions to provide healthcare or regulate the health sector as disruptive and undesirable. In case of a mismatch between the

[3] who would later go on to become the commerce secretary and deputy chairman of the planning commission in India

demand and supply of healthcare, the neoliberal logic would also prohibit state's intervention as the 'invisible hand' of the market, by its nature, tends to remain in an equilibrium.

A peculiar trait of the market fundamentalist approach towards healthcare is their presentation of healthcare as any other economic commodity that is ruled by the laws of demand and supply. Health sector according to this ideology is just like any other sector in the economy. this econometric approach to public health is extremely problematic and even derided by many economists themselves (Raworth, 2017). Healthcare as an economic goods or service also has a very high positive externality (Dreze & Sen, 2013). An externality is an indirect impact, either positive or negative, on individuals or groups who are not involved in a particular economic transaction. The impact of the economic activity of the service provider and the beneficiary goes beyond the two. That means that the indirect benefit of providing healthcare to an individual will extend beyond that one person; private gains transcend to become social benefits (McPake & Normand, 2008). This is especially true in immunization programs, where vaccinating individuals helps in preventing the outbreak or transmission of a disease. Automobile are classic examples of externalities. Vehicles pollute the air we breathe every time they are driven, slowly undermining the health of our ecosystem. This cost is borne not only by the vehicle's driver, but by all living things on the earth. In most health-care systems, the critical externality is the care offered to others particularly in cases of infectious diseases, gains from others' good health lowers one's chances of contracting an illness (Ibid)

Tax costs, infectious disease, antibiotic resistance, and environmental degradation are examples of negative externalities. Regardless of whether or not they participate in the system, the negative elements have an impact on others. Air pollution is one of the most cited example of a negative externality, an individual's action that contributed to pollution is based on the profit opportunity and the direct cost he/she would have to incur. However, others have to bear the indirect costs in terms of their health as a result of the increased pollution levels. Indirect costs can include degradation of quality of life, aggravation of health conditions etc. For a person living near a factory, the affects could be seen in higher health-care expenditures; on a larger scale pollution will also prevent more people to live in the area, restricting the business opportunities for others (Musgrove, 2004). Therefore, the total costs of such economic activities are higher than the cost which is borne by the producer. As the indirect expenses are not absorbed by the producer it is unlikely to be passed on to the end user as well who benefits from the product (Ibid).

in addition to externalities, another essential characterises the healthcare market is the presence of Asymmetric Information (Dreze & Sen, 2013). The healthcare practitioner, owing to several years of training and domain specific experience has a greater knowledge and understanding of the service compared to the patient or the consumer. Because of his or her lack of knowledge, the patient is ill-equipped to assess the quality of health care. To make matters worse, health-care quality is notoriously difficult to assess, and opinions among health-care providers may differ on what constitutes the highest level of service. As a result, there is no guarantee that in a private healthcare market, the best value for money would be provided by healthcare practitioners (McPake & Normand, 2008). An alternative to a state provisioning of health services is for the majority of a country's citizens to purchase medical insurance and for most healthcare facilities to be privately funded. Adverse selection and moral hazard are inherent concerns in medical insurance, as they are in other types of insurance (Dreze & Sen, 2013). When it comes to insurance, moral hazard occurs when the insured takes more risks than they would without it since they know they are protected. The premise underlying adverse selection is that those who will insure are the ones who will profit the most from it. Those who are aware of their proclivity for illness, for example, are more likely to want health insurance than those who believe they are well. As a result, the insurer is faced with an unfavourable candidate pool (Ibid). Insurers, on the other hand, have devised solutions to mitigate these issues. They set higher health insurance premiums for high-risk individuals such as smokers, to counteract adverse selection. Its typical of health insurance policies to not cover pre-existing diseases for a few years at the beginning of the coverage. Health insurance still faces considerable issues in terms of equity and cost-effectiveness. Critiques have argued that it is unfair to exclude pre-existing health conditions or to charge an increased premium as this is where one needs the insurance protection the most. Owing to these factors, even when the insurance market is large and well-functioning, governments are forced to interfere frequently to protect the high-risk individuals from health and financial risks (Ibid).

Another problem with the private healthcare model is the primacy of some services over other based on the higher profitability of such services. Private healthcare providers or even pharmaceutical companies invest more in products and services that are deemed to be more profitable or those which will potentially generate higher returns in the future (Ibid). There are examples to corroborate this as well; tropical diseases like malaria, kalaazar, dengue etc have not seen the kind of resource investments as others like coronary heart disease or cancer. Where a perfectly competitive market operates and there are no externalities, traditional economic

theory suggests that this does not matter; supply and demand will interact to ensure that consumers purchase goods at a price which reflects the marginal benefit to them and the amount produced and consumed would be at the socially optimal level. However as discussed above, healthcare's positive externalities and its status as a basic entitlement make it unacceptable as well as inefficient for its provision to be left solely to the private sector.

2.4.2 Market Failure and Regulations as redressal mechanism

The subject of regulation of the private healthcare market has been at the centre of some of the most contentious debates around public health. Critics argue that regulations have the tendency to interfere with and reduce the efficiency of the market, whereas advocates for stronger regulations argue that well designed regulations not only ensure that people's interests are protected but well-designed regulatory systems have the capacity to make markets more efficient and more equitable, ensuring better health outcomes (Witter, et al., 2019). Within the realm of social sciences, especially within economics, which as a discipline arguably has the biggest influence over public policy, academic thinking about regulation most often revolves around the idea of market failure. In ideal conditions, in a free market, individuals maximize their welfare by pursuing their own self-interest, which collectively leads to a shared benefit for all. In case of deviations, the invisible hand of the market forces itself to induce some course correction so that the market is moved towards stability. However, in real life situations, the invisible hand of the market often fails to optimize social welfare as factors such as externalities diverge individual and social welfare. During the prime of the Keynesian economic ideas, i.e., 1950s and 1960s, market failure was often regarded as a sufficient justification for government intervention by economists and policy makers (Balleisen & Moss, 2009). For instance, negative externalities such as industrial pollution, had to be controlled through administrative and legal regulations or taxation. However, by the late 1970s as the neoliberal ideas of unfettered markets began to gain prominence over the Keynesian idea of a controlled economy, economists began to pay more attention to government failure. There was an increasing tolerance for market failure and the larger consensus was being built that even in case of market failure, government interventions could potentially do more harm than good. As the NPM discourse gained strength in economic and policy circles, government failure increasingly displaced market failure as a dominant subject of studies. However, after the global economic crisis of 2008-09, some noted economists have started to strongly reverse this trend bringing market failure back into the central discussions using them as a strong critique of the blind free

market optimism (Ibid). Joseph Stiglitz identified a series of market failures in the recent times and argues for government intervention in the form of regulations to overcome these failures.

There are three major economic rationale for government regulation of the markets according to Stiglitz; Externalities, Market Irrationality and Redistributive Justice (Stiglitz, 2009). Joseph Stiglitz and Greenwald while deliberating upon the role of externalities in welfare economics, argue that economies where there is imperfect information and incomplete markets, which for all practical purposes all economies, need government interventions especially regulations to move towards attaining greater efficiency (Greenwald & Stiglitz, 1986). The reason behind the economic inefficiency in underdeveloped markets with information asymmetry is the increase in the impact of externalities. Therefore, governments must intervene to strike trade-off between competing groups so that in an attempt to improve one, another is not significantly worse off. Extending the argument, a little further, it is safe to say that greater the information asymmetry and lack of market development in an economy, bigger should be the role of the government to mitigate the impact of externalities.

Neoliberal economics borrows several of the basic economic fundamentals from the neoclassical school of economics, particularly ideas relating to demand and supply and market equilibrium. It also continues to believe in the neoclassical assumption about markets, that they are rational entities and by nature efficient. Rationality of markets stems from another assumption that consumers are rational decision makers when they have complete information. It is now widely accepted that markets often behave irrationally and extremely erratically. Even individual consumers are not rational decision makers because there is almost always an information imbalance, especially in healthcare services.

The goal of a market economy is to produce economically efficient outcome, which may or may not be socially just. Government interventions, including market regulations, prove to be an important instrument to achieve the redistributive objectives in an economy, provided the state actually intends to. This becomes all the more necessary when governments face tight budgetary constraints and allocation becomes extremely cost sensitive.

2.5 History of the neoliberal healthcare model

2.5.1 Health Sector Reforms

Health Sectors Reforms are a global phenomenon, which began in the 1980s, firmly rooted in the neoliberal framework and was based on the assumptions that expenditure on public systems

is wasteful; public systems like bureaucracy are inefficient and ineffective; markets need to be given greater prominence and market principles can be introduced in public systems to make them more efficient (Baru, 2017). In high-income counties, particularly in OECD countries, health sector reforms were concomitant to the New Public Management (NPM) reforms. These reforms provided the developed countries a framework within which public expenditure was reduced causing withdrawal of the state from sectors that were previously singularly dominated by it. Even though there was a palpable lack of evidence on the effectiveness of health sector reforms in developed countries and they were criticized for giving an undue emphasis on markets, the template of HSR was exported and replicated throughout the developing world (Sen & Koivusalo, 1998). A systematic effort to introduce neoliberal principles in healthcare in low-income countries can be traced back to the economic reforms that were introduced in the Latin American country, Chile in the late 1970s and 80s. these reforms were led by a group of economists who were ardent believers in the free-market principles and were trained at the Department of Economics at the Chicago University. These economists were known as the 'Chicago Boys' whose influence on the Latin American economies is still a subject to intense debates. The story of the Chicago boys has its origins in a scholarship that was started by Theodore Schultz, then Chairman of the Department of Economics at Chicago, with the financial patronage from USAID, then known as the International Cooperation Administration (Reinhardt, 2012). The purpose was to train these economists in the free-market traditions of Chicago economics, which will be used by them to challenge the centrally planned economy under President Salvador Allende. These Chicago trained economists were also expected to challenge the structuralist economic policies advocated by the University of Chile and the United Nations Economic Commission for Latin America (ECLA) at the University of Santiago (Ibid). As the Allende government was overthrown by a military coup in 1973, the Chicago Boys drew a blueprint for revival of the Chilean economy under the dictatorship of General Pinochet. Within a few years of the coup, the World Bank provided upwards of $2 billion to the military junta; other major creditors were the USAID and the IMF (Crittenden, 1976). This was a sharp contrast to Allende years when virtually all foreign aid or credits were stopped. Milton Freidman justified these credits extended to a military dictatorship arguing that economic support is independent of political support. His role as an unofficial advisor to the Pinochet regime began in 1975, a year before he received his Nobel prize in economics, and in the next few years, he became the poster child of the free-market enterprise in Chile (Letelier, 1976).

Chile had introduced the National Health Service (NHS); general tax revenues and social security contributions were used to finance a public health system. NHS along with a voluntary health insurance scheme covered more than 90% of the country's population; significant improvement in people's health indicators were recorded through the 1960s. One must bear in mind that it was always ingrained in the Chilean political thought that healthcare should be guaranteed by the state; healthcare was declared as a human right in the country's constitution implemented in 1925. The Pinochet regime revised the constitution in 1980 but even the new constitution recognized healthcare as a human right and fixed the ultimate responsibility of providing it on the government. However, it did deviate significantly from the earlier model of publicly funded and publicly provided healthcare declaring that every person should get a choice to opt for a public or private health service (Reichard, 1996). The new regimes choice of opting for a market-led health system was apparent when its then Health minister proclaimed that 'healthcare is not given, rather, it must be obtained by the people'(Ibid). Even though the national health system in Chile was not perfect, it reflected the spirit of healthcare as right of every human being and it was the government's responsibility to ensure that the right was protected and fulfilled. This socialist model of healthcare had not only survived the post-World War II onslaught of capitalism but its performance was akin to or surpassed market led healthcare models where the government's expenditure on healthcare was several times higher than in Chile. Unsurprisingly, the reforms introduced by the Chicago school-junta partnership also introduced structural changes in the health sector in the form of health sector reforms. The reforms formally began in 1979 when the NHS was decentralized into 26 regional services, followed by the introduction of private health insurance in the primary health facilities in 1981 (Navarro, 1974). In the next ten years, private insurance market was expanded to tertiary care. By the end of 1980s, public health system as a source of healthcare had reduced to 35% compared to 61% in 1974 (Reichard, 1996).

Throughout the 1980s, the World Bank by publishing a series of reports on the health sector had made it clear that health financing was a policy priority for the Bank. The 'Health Sector Policy Paper' of 1975 was the first one in a series of reports dedicated to the health sector. in a second policy paper of 1980, it teased the idea of user fee in government health facilities but didn't recommend it as a policy measure because 'it was unpopular with local governments' (World Bank, 1980). Another policy study published in 1987 by the Bank contained the blueprint of the reforms that would soon become a common feature across health systems in low-income countries. Bank's eulogizing the private healthcare market in this paper was a

deviation from its earlier policy papers that highlighted the risk of market failure in healthcare. It also promulgated the idea of introducing user fee in public health facilities so that more resources could be generated (World Bank, 1987). In total, four recommendations were made in this report forming the core of the health sector reforms. They were,

- Introduction of user charges in government health facilities,
- Use of private insurance to reduce the financial burden on the government,
- Encourage participation of non-government sector, both non-profit and for-profit,
- Decentralization of health services and use of market incentives to motivate healthcare workers (Ibid).

By the beginning of the 1990s, several policy documents brought out by the OECD gave a more wee-defined shape to the idea of health sector reforms. A Forum on Health Sector reform was constituted within the World Health Organization, which had published five discussion papers by 1995 on the need for health sector reforms and gave frameworks for its implementation in low-income countries (Saltman, 1995). One of these papers blamed the inefficiencies in the governments and bureaucracies for poor health in low-income countries and recommended six components that required to be included in a health sector reform program. They have been consolidated into four major recommendations here:

- Improving performance of health ministries and government employees reducing the number of employees and introducing performance related incentives.
- Broadening of health financing option by introducing user fee in government health facilities, private and social insurance schemes.
- Increased access to the private sector through contacting and other similar mechanisms, ensure competition among providers and establishing regulatory systems.
- Decentralization of health services including introduction of self-governing hospitals (Cassels, 1995).

Basically, the reforms targeted three specific areas in the healthcare sector namely, financing, provisioning and governance and envisaged a greater role of markets mechanisms across the three categories. It must be specified here that these reforms were not a continuation of the reforms that led to the Alma Atta declaration in 1978, which was focussed on the primary healthcare. Although both reforms espoused the idea of decentralization of health services; the end goal was different. The focus of decentralization of the reforms in the 1970s was on

community involvement and a bottom-up approach of health policy; health and development were considered interrelated and 'felt needs' of people were to be included in health policy ecosystem (WHO, 1978). Whereas, the focus on the 1980s reform was on loosening government control over healthcare and allowing non-government entities, both non-profit and for-profit to play a bigger role. As economies across the world were reeling under the post-Keynesian economic distress and several of them were under a lot of debt that had become difficult for them to repay. Lack of resources combined with the belief that the government/ bureaucracy/ civil services were inefficient and caused a lot of wastage of resources drove the idea of health sector reforms. These ideas also formed the basis of the New Public Management (NPM) reforms that emerged as a response to Keynesianism in the 19080s. NPM was founded on the belief that private-sector management approaches were vastly better than the bureaucratic principles of public administration. Key elements of these reforms included decentralization of public services, increasing use of market principles like increased competition, contracting-out of services, introduction of user fee for availing public services etc and increased emphasis on productivity and cost-efficiency (Larbi, 1999). A more detailed analysis of NPM principles and their role in furthering the neoliberal cause in general and public-private partnerships in particular will be discussed in the next chapter. For now, the vast commonalities between the NPM reforms with the health sector reforms is evident. The restricting of public services through the introduction of market mechanisms was at the core of both reforms. This led to the realignment of the state-market dynamics, where role the state and its organs was further restricted and more efficient market became bigger and more powerful in the economy. 'Optimal utilization of limited resources', the mantra of neoclassical economics that was used to campaign for increased marketization of health services by health sector reforms and of the economy in general by NPM.

In case of India, health sector reforms are dated to introduction of the liberalization policy by the Narsimha Rao government in 1991 (Bisht, 2017). However, others have rightly pointed out that the country had taken a turn towards neoliberal reforms much before that (Kohli, 1989).. For the health sector in India, the move towards increased role of markets including opening up of the sector for private investments could be recognized by the early 1980s (Kapilashrami & Baru, 2018). The post-emergency government led by PM Mrs. Indira Gandhi prioritized economic growth while ignoring redistribution concerns, which was a trademark of her earlier stint as the prime Minister. The new government south to partner with big business, adopted anti-labor policies, reduced the significance of central planning and restricted the growth of the

public sector (Kohli, 2006). An advisor to the government of Indira Gandhi had claimed that her government was "was clearly determined to get back to the firm foundations of economic reform" (Ibid). The 1983 National Health Policy also recommended expanding healthcare through the private sector. Rajiv Gandhi's government, with his economic advisors that included Manmohan Singh and Montek Singh Ahluwalia had made it clear that economic liberalization was its policy priority (Kohli, 1989). It relaxed import restrictions, reduced corporate and individual taxes and opened up sectors previously catered exclusively by the public sector to the private sector. Healthcare was one such area where state's dominance was watered down. It is natural that these economists, heavily influenced by the free-market ideology and having worked in the World Bank and the IMF were keen on reforming the health sector in India. The Sixth Five Year Plan (1980-85) recommended that the private sector's role in healthcare be expanded. The hospital industry was designated as an industry in 1986, which meant that public financial institutions may lend money to it. Customs duty on high-tech medical devices had also been reduced. Government also provided tax-benefits and subsidies to private hospitals that were registered as trusts (Thomas & Krishnan, 2010). During the lates 1980s, fiscal concessions in the form of reduced import duties on medical technology were introduced by the Indian government (Baru, et al., 2001). It is clear that the reform of Indian health sector had begun much before the liberalization of the Indian economy. However, beginning of the 1990s is still a significant milestone because it was the time when Structural Adjustment Program was implemented in India. SAP provided the biggest impetus to the health sector reforms in India. Privatization coincided with huge developments in medical technology. At the same time, governmental outlays for health were stagnant and even declined. During the lates 1980s, fiscal concessions in the form of reduced import duties on medical technology were introduced by the Indian government. Healthcare was also granted the status of an industry; therefore, private corporate hospitals were able to mobilize international capital for setting up of big tertiary care hospitals (Baru, et al., 2001). Over the years, the government had reduced its expenditure on health and it had fallen from 3.30% in the mid-1950s to 1.80% by the beginning of 1980. Public sector hospitals had insufficient funds to keep pace with technological advances. Private hospital enterprises like the AHG (followed by others like Max, Fortis and Wockhardt), entered the space (Ibid). All have employed the strategy of lobbying the government for concessions, promising free or subsidized treatment for a percentage of patients, a commitment that has remained more or less unfulfilled. For example, the twelfth report of the Public Accounts Committee 2004-2005 (Fourteenth Lok Sabha) which deals with allotment of land in Delhi at concessional rates to hospitals, remarked that;

> "Ultimately, what was started with a grand idea of benefiting the poor turned out to be a hunting ground for the rich in the garb of public charitable institutions. The record of allotment of land to 42 hospitals and dispensaries revealed various irregularities and shortcomings in both the allotment of land and in enforcement of the terms of allotment, which defeated or undermined the very purpose of allotment of land…at concessional rates…monitoring of adherence to the terms and conditions of the concessional rates was conspicuously non-existent." (Jeffery, 2019, pp. 88-89)

Foreign Direct Investment (FDI) in the hospital sector in India was permitted up to 100% under the automatic route in the year 2000. Approval from the Foreign Investment Promotion Board (FIPB) was to be required only for foreign investors with prior technical collaboration. Other forms of capital mobilization, such as through ADRs and GDRs[4], up to 49 percent, which are treated as FDI were also allowed subsequently by other regulations in later years. Foreign Institutional Investors (FII) as well as private equity funding up to a certain extent is also allowed under the FDI route (Chanda, 2015).

2.5.2 Debt refinancing and Structural Adjustment Programs

International Financial Institutions (IFIs) have had a tremendous influence on the global economic landscape and have been described as "the world's most powerful agents of economic reform" (Halliday & Carruthers, 2007). In the history of global lending institutions, economic crisis has often proved fortuitous for lenders. Borrowers are more desperate for credit that makes them more amenable to meeting stringent conditions. The foundations of the Adjustment Policies were laid in the global economic crisis of the 1970s. Developing countries were the worst affected by the crisis. Investments from developed counties reduced drastically and demand for commodities from these countries also dried up, dampening the exports from developing countries leading to an increase in current account deficit in the developing world (Toussaint, 2008). United States increased interest rates to control increasing inflation and this caused a crisis of balance of payments in borrowing countries. Developing countries needed funds to overcome the Balance of Payment (BOP) crisis and to ensure that there were no defaults in the service or repayment of borrowing that these countries had from the developed

[4] Global Depository Receipts are financial instruments through which domestic companies raise foreign capital through a depository bank. For instance, an Indian company can issue Euro GDRs through SBI which a foreign investor can buy and become an investor in the Indian company. An ADR (American Depository Receipts) is when the instrument is issued in US dollar.

countries as well as multilateral institutions. Loan service payments increased dramatically, and highly indebted developing countries were unable to repay the debt. The debt crisis of the 1980s is widely regarded to have started when Mexico announced in August 1982 that it would no longer be able to fulfil its debt (UNDESA, 2017). This set off a chain reaction of sovereign defaults around the world (Ibid). In 1979, Robert McNamara, former defense secretary of America and then president of the World Bank urged the international community to provide additional financial support to developing countries that were ready to undertake 'Structural Adjustments' (Word Bank , 2014).

Reduction of fiscal deficit was elemental to the financial strategy of the SAP program, it could either be done by increasing revenue income or by reducing expenditure or doing both. Indian government was forced to restructure its expenditure patterns because of the limited base of tax revenue, both from central and state governments. As a result, in the post SAP years, central and several state governments went through the process of expenditure reduction, mostly from economically non-productive social sectors. In the restructuring process, a squeeze in the health and social sectors' spending was observed at the national and state levels (Kumar, 2016).

The SAP along with bank-supported health system reforms have generally been the driving force behind the state's diminished participation in healthcare provisioning, resulting in the government's failure to meet public health-care needs (Kumar, 2016). India had made a commitment to provide Health for all by 2000 at the Alma Ata declaration in 1978. Towards this end some investment was made in rural health infrastructure that include a network of publicly funded healthcare institutions across the country- subcenters, primary health centers and district hospitals as well as social support programs including nutritional programs (Rao, 2010). However, the economic crisis of 1980s and the bailout conditions imposed by world bank and IMF, among other factors, contributed to a sustained reduction in healthcare spending by the government over subsequent years (Ibid).

India took a plunge into this lending mechanism in 1991 to avert the huge balance of payment crisis. Total external debt shot up from Rs. 1511 billion in 1990-91 to Rs. 2559 billion in 1991-92 (Prabhu, 1994). During FY 1990-91, inflation ran in double digits, import bills had almost trebled, NRI deposits had crashed and foreign exchange reserves were at an all-time low (IBRD and IDA, 1991). These factors precipitated in a balance of payment crisis. There was a significant drop in India's credit worthiness in the global capital markets; external funding became very expensive and hard to come by. IMF and the World Bank offered a much-needed

financial impetus to the Indian economy, however, the assistance was conditional to a set of macroeconomic and fiscal reforms to be carried out in India. Known as the 'Structural Adjustment Loans/Credits', these funding programs were designed stabilize and reform the economies, abiding by the neoliberal tenets of privatization, deregulation and liberalization of the economy (Pritchett & Summers, 1993). While these reforms were able to restore macroeconomic balance in borrowing countries to some extent, their human cost, particularly their impact on public health and education received widespread criticism. India opted for a World Bank funded Structural Adjustment Loan in 1991. It entailed greater reliance of market forces and reduced state control on the economy, reduction in government expenditure, withdrawal of subsidies and divestment of state enterprises. The loan was divided into two tranches and the second tranche was to be disbursed on the 'satisfactory fulfillment of these conditions' by India (IBRD and IDA, 1991). These policy reforms mirrored the spirit of the 'Washington Consensus' prescription. Some of the recommendations/conditions that were made in the loan document were: Expenditure cuts and Tax reforms, Deregulation of domestic industry, Promotion of Foreign Direct Investment, Liberalization of Foreign Trade Regime, Reforming the domestic interest rate policy and adoption of free floating exchange rate, Dilution of government ownership in public enterprises, Eliminate regulatory barriers to entry and Removal of import licensing and tariff reduction (Williamson, 1993).

For the health sector it led to reduction in government's expenditure on health, fostering of private health services and greater reliance on markets and market principles for healthcare provisioning (Baru, 2003). In addition to the public expenditure on healthcare, the PDS (public distribution system) for food grains was also severely curtailed in the post SAP years (Rao, 2010). It proved to be a double whammy as the reduced expenditure on agriculture and allied activities such as irrigation, infrastructure and rural credit led to decline in per capita availability of food grain (Ibid). The emphasis was on increased commercialization of public health and facilitating the growth of private sector. The adverse health impact of adjustment policies on Indian public health system have become palpable now. Chronic underfunding has led to dilapidated infrastructure in many states, shortage of health workers across categories, increased reliance on external donors and one of the highest Out of Pocket health expenditures in the world.

When India signed the SAP deal with WB, adjustment policies were more than a decade old and the criticism that these policy prescriptions were too austere and arguably harmful for the

social sectors was widely accepted. UNICEF was one of the earliest and the staunchest critiques of the impact of these policies on children's health status across borrowing countries. In its annual report in 1987, said that in many countries these policies not only failed to reverse adverse economic developments, they also contributed to increased poverty and worsening of children's health. It was soon realized that although the need for macroeconomic adjustments was there during the 80s and the 90s, the contours of the WB led adjustment were questionable and the human cost of it was significant. These policies were criticized for slowing down of demand, devaluation of the currency, rise in prices led by withdrawal of subsidies and deep cuts in government spending that proved detrimental particularly for social sectors (UNICEF 1989). In its report on the state of the world's children in 1989, UNICEF observed the immediate impact of adjustment polices on increasing IMR in host countries. The report said that these policies had brought the social progress achieved in decades to a halt and in some cases reversed it (UNICEF 1989).

However, despite mounting criticism, the Bank continued with the adjustment policies. In fact, its policies towards the health sector were shaped by the SAP ideology. As it was one of the largest funding agencies in global health, these policies had far-reaching implications for public health in developing countries. Although the Bank had been lending for health-related projects since the beginning of the 1970s, the report of 1987 and 1993 set the platform for a market-led and deregulated health sector in borrowing countries. The WDR of 1993 was pivotal in this regard. It reiterated the need to introduce user charges in government health facilities for increased resource generation. World Bank's advocacy for increased private participation in healthcare was drawn out more specifically in this report. It recommended 'scaling back' of government run health systems in developing countries (World Bank, 1993). The report recommended that a government should restrict itself to running public health programmes that have large externalities like immunization and providing a carefully selected package of public health services. Further recommending that it should desist from investing in tertiary care hospitals and should facilitate private health providers, both for and not for profit to provide most of tertiary care services (Ibid).

2.5.3 Impact of SAP on India's health sector

Most of the developing countries who were beginning to build a system of state-led welfare services model, were adversely affected by the neoliberal wave that gain huge momentum in the 1970s. While countries like Brazil and South Africa, who had deep rooted political

commitment to the welfare of the marginalized people, managed to keep their investment in the health sector between 4-6% of the GDP in the face of a strong push for privatization; India on the other hand gave in and opted for large scale privatization of its healthcare services. (Qadeer & Chakravarthi, 2010) Results of structural adjustment in India were in many ways similar to other countries, rise in income inequality was also reported from India after the SAP years. Several studies also reported a rise in income inequality in India in the adjustment decade (Deatn & Dreaze, 2002); (Sen & Himanshu, 2004). The average GDP growth in India in the decade of SAP (1991-2000) declined to 4.9% compared to 5.5% in the previous decade (World Bank, n.d.). Unemployment rate grew from 5.9% in 1994-94 to 7.3% in 1999-2000 (Pal & Ghosh, 2007). An analysis of income tax records reported that most of the economic gain in the 1990s was captured by the ultra-rich (Banerji & Piketty, 2015).

Average GDP growth in India in the decade of SAP (1991-2000) was 4.9% compared to 5.5% in the previous decade.[5] A UN survey reported that unemployment rate grew from 5.9% in 1994-94 to 7.3% in 1999-2000 (Pal & Ghosh, 2007). Based on consumption data from the 55th round of NSS survey, government of India reported a decline in poverty from 37.3% of the population in 1993-94 to 27% in 1999-2000 (NSSO, 2001). However, several economists that poverty reduction based on 55th round was an overestimation (Deaton & Kozel, 2005) (Sen & Himanshu, 2004). An analysis of income tax records by Abhijeet Banerjee and Thomas Piketty reported that most of the economic gain in the 1990s was captured by the ultra-rich (Banerjee & Piketty, 2005).

> "The results suggest that the gradual liberalization of the Indian economy did make it possible for the rich (the top 1 percent) to substantially increase their share of total income…although in the 1980s the gains were shared by everyone in the top 1 percent, in the 1990s the big gains went only to those in the top 0.1 percent" (Banerjee & Piketty, 2005, p. 19).

Several studies also reported a rise in income inequality in rural India between 1993-94 and 1999-2000 (Deatn & Dreaze, 2002); (Sen & Himanshu, 2004). Adjustment policies had a particularly damaging impact on the public healthcare system in India. The fiscal constraints that followed the adjustments took a huge toll on government's expenditure on health. Government expenditure on health in FY 1992-93 was reduced by more than 30% compared

[5]https://data.worldbank.org/indicator/NY.GDP.MKTP.KD.ZG?end=2019&locations=IN&start=1961&view=chart

to FY 1991-93; 0.6% of overall expenditure (World Bank, 1992). Budget for Malaria and TB Programs were reduced by 43% and 16% respectively and funding for health research was halved in the same period (Ibid). Overall, expenditure on programs with large externalities designed to benefit the poor were reduced in 1992-93 compared to the previous year (Ibid).

As the share of public expenditure on health was declines owing to the pressure to reduce fiscal deficits, another important development took place during the Eighth Five-year Plan (1992-1997) was the introduction of user fee in government health facilities. This was in compliance with the recommendation made by the World Bank in its annual world development report of 1987. During the decades of 1990s and 2000s several states initiated other World Bank recommended and sponsored health system reforms that further increased financial burden of healthcare on people (Ghosh, 2011).

The introduction of user charges in government health facilities led to reduced access to these facilities, especially for the poor (Gangoli, et al., 2005). Private healthcare sector also benefitted the withdrawal of the state from healthcare and the introduction of user charges in public hospitals (Duggal & Jadhav, 2018). A comparative study of NSS survey reports published in 1992 and 1996 found that the utilization of public health facilities declined by more than half from 1986-87 to 1995-96 (Sen, et al., 2002). Privatization was a self-professed strategy of the World Bank-IMF combine and it is no surprise that in their influence, the neoliberal thrust to privatized healthcare in India was significant. According to the Structural Adjustment Loan document of 1991, the World bank's operational strategy emphasizes, among other things to,

> 'Increase emphasis on private sector development (in close cooperation with IFC) and an orderly retrenchment of the public sector as an essential element of the structural program.' (IBRD and IDA, 1991, p. 33)

However, the significant rise in the share of privately provided health services failed to improve access to healthcare as private services were largely restricted to urban areas and richer states (Baru, 2006).

With India confronting an economic crisis in the 1980s, there was a significant growth in the use of commercial medical services, with explicit government support. The 1983 National Health Policy recommended expanding healthcare through the private sector. The Sixth Plan (1980-85) also recommended that the private sector's role in healthcare be expanded. The

hospital industry was designated as an industry in 1986, which meant that public financial institutions may lend money to it. Customs duty on high-tech medical devices had also been reduced (Thomas & Krishnan, 2010). Commercial medical services expanded rapidly, not just at the primary level but also at the secondary and tertiary levels. Individual doctors or small groups of providers practicing in nursing homes dominated the private market until this point. These hospitals couldn't afford the capital costs of cutting-edge technologies, which could only be found in government-run tertiary care facilities (mainly medical college hospitals) or in charitable trust hospitals with more resources. In this scenario, specialized medical treatment was made available to everyone, regardless of their socioeconomic status, at least in theory.

2.6 The State-Class alliance in neoliberalism

Neoliberalism is said to be the ideology of the elite classes; neoliberal policies help the elite to amass more wealth and resources and it perpetuates systems that allow these classes to accumulate exponentially larger share of resources vis-à-vis rest of the population (Navarro, 2007). World over inequality has increased wherever neoliberal policies have driven state's policies. More and more resources and vast amounts of wealth are concentrated with a small percentage of the elite while large number of people continue to suffer due to the lack of basic necessities. India has emerged as one of the most unequal countries in the world where inequality has risen sharply in the last three decades (OXFAM, 2022). Thomas Piketty has shown how the high levels of private wealth attained by the developed countries in the 1980s and the 1990s were also accompanied by significant increase in wealth inequality in these countries (Picketty, 2013). Although neoliberal agencies like the World Bank aided by a global financial crisis did play a pivotal role in the implementation of neoliberal policies in less developed countries like India, it would be wrong to assume that international institutions forced their ideas on developing countries and the host countries were mere passive recipients without any agency of their own. The 'impostional perspective' that international development banks and others exercised so much power on an agency-less country is engaging in selective retention of available evidence. Government of India did not just acquiesce to the demands of the World Bank and IMF but rather it negotiated its terms with them has been argued by scholars (Baru & Mohan, 2018). It was the country's elite that was in consonance with the neoliberal ideas. That is why it is necessary to look at the spread of the neoliberal ideas from the Marxian political economy framework. Marx and Engels argue how the ideas of the elite are at every point in history, the ruling ideas. The class which is the ruling material force of

society, is at the same time its ruling intellectual force. The class which has the means of material production at its disposal, has control at the same time over the means of mental production. In India, unlike many other low-income countries in Africa, neoliberal ideas were already influencing national policy even before 1991; political elite and administrative bureaucracy that included both medical as well as non-medical civil services, academia and civil society, were accordant with the neoliberal ideology and played a crucial and pro-active role in supporting the dissemination of neoliberal ideas and the structural adjustment policies (Baru & Mohan, 2018). Developing countries like India have witnessed a rise in the number of market forces participating in public provisioning. However, the rise is not backed by evidence for the social and political benefits of increased participation of market forces. Rather, their rise backed by neoliberal economic policies is often due to the lack of a perceived alternative and/or the powerful pressure on governments by international lending agencies (Ibid).

2.6.1 Resurgence of neoliberalism

Repetitive cycles of growth and degrowth have come to be recognized as part of the capitalist economic system. Economists have been grappling with this characteristically uncanny phenomenon for several decades now; attempting to find the causes of why a period of slowdown invariably follows a period of high economic growth and how it can be prevented or mitigated. Often this cycle of prosperity and depression, known as Business Cycles, have led to the fall of one form of economic system to be replaced by another (William H. Sewell, 2008). Business cycles were an integral part of the macroeconomic analysis of several leading economists of their times including Marx, Keynes and Hayek (Sherman, 1967). The rise of Keynesianism was a result of the failure of the neoclassical economics to predict or prevent the great economic depression. The cycle remained unaltered and ultimately caused the fall of Keynesianism after the economic crisis of 1970s giving rise to neoliberal capitalism. However, neoliberal managed to survive the survive the cyclical downfall of the global economy that precipitated in the form of 2007 sub-prime crisis. Neoliberalism's ability to adapt and survive crises is unlike any other form of the capitalist economy. In fact, it not only survives but uses these crises to its own benefit.

There are two possible reasons for this seemingly counterintuitive turn in neoliberal capitalism's history. Before this, every time one form of capitalism reached its ebb, it was replaced by another. Post facto analysis by scholars find three reasons for the perseverance and rather strengthening of neoliberalism in the post 2007-09 global financial crisis. One was the

unprecedented network of neoliberal institutions, think tanks, lobbyists and people within the government policy circles. Never before any form of capitalism had an organized presence across key institutions across the globe as neoliberalism, this was the biggest success of the idea of the Mont Pelerin society. Second, was the shifting the responsibility of the failure on some delinquent individuals, so it was not the failure of capitalism but the failure of a motley group of individuals to follow ethical practices (Amable, 2011). The state failed to regulate these rouge individuals, which ultimately precipitated into a full-blown economic crisis. In a way it had fallen upon the state to 'make bad capitalism good again' (Bruff, 2013). Third and perhaps the most significant reason was the rise of 'neo-fascist neoliberalism alliance' as describe by Prabhat Patnaik or Authoritarian Neoliberalism as described by Ian Bruff (Patnaik, 2021) (Bruff, 2013). A seemingly contradictory partnership between economic liberalism and political authoritarianism has provided a new breeding ground to neoliberalism. The compromise neoliberalism had to do is to forego the ideals of political and cultural liberalism, which were never really high on its agenda anyways; whereas the compromise political authoritarianism had to do was to forego economic protectionism and allow free flow of capital.

2.7 Neoliberalism and public-private partnerships in the health sector

Neoliberal ideas have been the force behind the global economies have organized themselves since the 1980s. Being the dominant economic model and carried along by key global economic institutions, it has affected all sectors of any economy including health. The choices that countries make in their health policy and planning are also affected and to a large extent determined by the neoliberal ideas. What is the state's role in the health sector, how will market forces shape and restructure the sector and what role will people play in this sector; of a buyer or a stakeholder; these critical and fundamental questions are defined and answered within the neoliberal framework. Since its introduction in less-developed economies like India, neoliberal policies pushed for a greater role of market forces in the health sector. during the initial years it was privatization of health that was high on the neoliberal agenda. The global economic crisis of 1980s was used to open previously closed social sectors, restrict government spending through austerity measures forcing them to choose private finance. These measures proved to be detrimental to the public health systems in these countries that was already reeling under lack of government investments. Withdrawal or limited involvement of the government in the sector proved to be conducive for the further expansion of the health market in India.

The next global economic crisis trigged by the American Banking system in 2007-08 forced countries to limit their expenditure and once again sectors seemingly contributing to the economic production system had to bear the burnt. The private health sector, which had become stronger during the previous two decades or so as a result of the neoliberal restructuring was not presented as an alternative, a work-around, to overcome the lack of resources. Economies weakened by the economic distress relied upon the private sector, both for as well as not-for profit, multilateral banks global philanthropic organizations. A new and distinct phase in the health sector was marked where public-private partnerships became the model of choice for most stakeholders including the state, private sector and transnational organizations.

Conclusion: What neoliberalism has done is changed the traditional markers of value in social sectors like health and education. Good health and wellbeing of people, improvement in their quality of life and their living standards, parameters of social justice, equity and fairness have been replaced by markers such as demand and supply, efficiency, productivity and most importantly profit. This has commoditized and marketized services that were traditionally considered public goods. The philosophy that a market-based economy is superior to other political-economic frameworks is the bedrock on which neoliberalism has thrived. And a market free from government oversight or intervention is the most efficient market. Although neoliberal policy has led to unprecedented economic growth in so many countries, it has also highlighted the fact that free markets and private enterprise are just not suitable for certain area and have failed again and again. These failures eventually have a negative effect, especially on the social development indicators. There is an indomitable body of evidence that supports the claim that neoliberalism spawns economic growth but hinders social development.

However, the promise of neoliberalism and the claim of superiority of its tenets have failed to materialize. Despite having been a dominant policy driver in several developed as well as less developed countries for several decades now, key neoliberal claims like the superiority of market forces over state interventions, private management practices over existing administrative systems among others have not produced evidence to support their claims. All over the world neoliberal policies have led to increased inequality; the argument that the benefits would eventually trickle-down to all sections of the population has failed.

Chapter III: Public-private Partnerships in Healthcare; Fundamental ideas, Political economy, Global and National Scenario.

Public-private partnerships have become integral to the way public health is organized and provisioned across the world. They are one of the key strategies adopted by the United Nation to enable UN agencies to be more effective and efficient (Richter, 2004). The idea that the best of both public sector and the private sector can come together to bring out improved health outcome, which either of them fail to elicit individually, has gained popular acceptance. Working with private sector enterprises is also claimed to be a way for public sector organisations to have access to unique resources and competencies in order to achieve better health outcomes. Constituents of these partnerships have also evolved from the traditional definitions of purely public and private entities to now include philanthropic organizations, development institutions, multilateral institutions including financial institutions like international development banks, not-for profit organizations and charitable institutions among others. This development has also forced health policy researchers to re-look and redefine what the public sector is and where does the ultimate responsibility for ensuring health and wellbeing for everyone lies? Even though PPPs have been prescribed as a panacea to the welfare issues of low-income countries the success or failure of PPP projects has not been systematically assessed in these contexts (Rosenau, 1999). The PPP debate is still largely conducted in the neoliberal framework of "public bad-private good", informed by selective evidence from NPM and pro-privatization literature. These debates have well to exploit the general lack of trust that people in low-income settings have for their governments.

Conceptually there exists a lot of ambiguity or to be more precise a lot of overlapping when one attempts to define what is 'public' and what is 'private'. As the nature of the state-market relationship has evolved over the years taking its current neoliberal form, the nature of 'public', 'private' and the interconnectedness between the two has also adapted accordingly. Until the end of Keynesian era in the 1970s, public services were provided by the state, both in developed as well as less developed countries; to an extent that public service and public sector were used synonymously (Grout, 2008). However, the advent of neoliberalism led to the withdrawal of the state not only from several areas of economic activities like production of goods and services but also from the providing public services. As the size and scope of the public sector comprising economic activities controlled by the state shrank; the private sector began to provide more and more public services. However, private companies are driven by the goal of

profit maximization for their shareholders; therefore, their reach as well as the kind of services they will provide are driven by profitability. This led to the growth of non-profit organizations who don't claim profit maximization for the shareholders as their most important goal (Ibid). While the profit motive and its consequences are generally considered a central characteristic of the private sector, not for profit non-government organizations proved that they are not essential anymore. National and international NGOs, philanthropic organizations, non-profit consultants among others are some of the types of these organizations. Many of them rely on government patronage in terms of funding and contracts for their survival. For the purpose of this research ownership and control are the defining characteristic to determine if an organization is public or private. Whether the goal of the organization is profit making or philanthropy is not considered as a defining variable here. Therefore,

- Public will refer to all institutions that are owned, controlled and managed by the state.
- Private will include all institutions including individual entrepreneurs whose ownership, control and management is not done by the government. This includes both for-profit and not-for-profit organizations as well as private philanthropic foundations.

3.1 PPPs: Popular yet problematic

In the context of the growing strength of the neoliberal model of healthcare, the attempts to define healthcare as any other tradable commodity has gained tremendous prominence. The idea that market forces are best equipped to provide healthcare to all has found acceptance in health ministries, government think tanks and health policy makers despite a large body of evidence to show that markets are not redistributive and equitable and have often failed to benefit people living on the economic, social and political margins. Additionally, PPPs have ensured that private interests are embedded more and more in areas that were previously considered to be the responsibility of governments; leading the charge of marketization of previously state-dominated sectors like health and education. They have also enabled and emboldened nation states to shirk their responsibility for the promotion and protection of people's health. Partnerships could dangerously legitimise the removal of social safety nets and ostensibly absolve public authorities of the responsibility for breaking the social contract with its people.

According to the World Bank, “conceptually, public-private partnerships are an instrument to respond to market failures while minimizing the risk of government failure” (World Bank, 2015, p. 1). However, it seems contradictory that the same set of market principles that often lead to market failure are used to address market failure, instead of trying alternative strategies. The fundamental tenet supporting the increased utilization of PPPs in healthcare is that the private sector is essentially better at doing some things more efficiently and by extension the same ideas and practices that are effective in solving business problems can also solve problems that have been plaguing public health for decades. This is contrary to the fact that healthcare is much more complex, multifaceted and systemic than any typical business problem. Public health discourse over a number of decades have established that health is as socially, economically and politically determined as it is determined clinically. This chapter will look at some of these irreconcilable narratives that have pushed the PPP agenda globally and will also look at the role of some institutions that have been critical in popularizing this agenda. It will also place PPPs in the larger context of the neoliberal marketization of public health and argue that PPPs must be looked at as a part of the larger strategy. Therefore, PPPs in healthcare and privatization of healthcare are not two mutually exclusive phenomena but rather two often overlapping tools of the same strategy. It will also present the global history of PPPs in healthcare and look at the factors that precipitated their spread from developed economies to less developed economies like India.

3.2 Defining public-private partnerships:

While addressing the World Health Assembly in 2002, the then Director General of WHO had famously said that partnerships in healthcare are inevitable as the problems in health are too complex to be solved by governments, private sector or philanthropic foundations individually (Brundland, 2002). This unequivocal endorsement from the top leadership of the WHO indicates how absolutely integral PPPs has become in the global health landscape. However, despite their widespread popularity among policy circles, think tanks and consultants and multilateral institutions, there are a lot of conceptual contradictions within the idea of PPPs as well are variations in the ways they are defined. Many scholars have argued that the overwhelming optimism surrounding PPPs in healthcare is not built on critical evidence. Partnership became the commanding slogan of neoliberal macroeconomics at the turn of the 21st century in public policy and governance literature. However, the belief that “it is ‘good thing’ seems much more a matter of faith than of science” (Wettenhall, 2003, p. 80). Faranak Miraftab argues that PPP definitions tend to be mechanical, reduce the complexities involved

in such collaborations and the context in which such partnerships and collaborations happen. Focusing mainly on the logistics and typology, these operative definitions downplay the role of power networks that exist and define a partnership (Miraftab, 2004).

Even though the term ‘Partnership’ is widely used to express some form of a collaboration between entities, there is hardly any agreement on ‘how to define a partnership’. According to WHO, Public-private partnerships are defined as those alliances that bring together a group of players with the common goal of enhancing a population's health through mutually accepted roles and principles. (Buse & Waxman, 2001). Hodge and Greve aptly capture the disparate nature of these arrangements as well as the attempts to define them by policy makers as well as academicians. They argue that PPPs are not as much a concept as they are ‘family of techniques’, which circumscribe all types of state-market or government-business arrangements (Hodge & Greve, 2005). Taking an almost similarly broad-stroked view of organizing PPPs, Emanuel Savas defines a public- private partnership as any arrangement between government and the private sector in which partially or traditionally public activities are performed by the private sector (Savas, 2000). This is evidently a very general and broad definition that could cover all types of arrangements between a government and the private sector can be categorized as a public-private partnership without going into the details such as value addition or risk sharing. The United Nations define partnerships as voluntary and collaborative *relationships* between various parties, both State and non-State, in which all participants agree to work together to achieve a common purpose or undertake a specific task and to share risks, responsibilities, resources, competencies and benefits (United Nations, 2004). The World Bank has been rather generous to the private sector in defining PPPs and it is perhaps the only definition that claims that the risks of the private sector overweigh the risks of the public sector in a PPP. It defines a PPP as “a long-term contract between a private party and a government agency, for providing a public asset or service, in which the private party bears significant risk and management responsibility” (World Bank, 2014, p. 14). According to the United Nations Economic Commission for Europe (UNECE), PPPs are long-term service agreements that are implemented to finance, design, implement and operate public sector facilities and services (UNECE, 2008). Public- private partnerships are also defined as agreements between government and the private sector organizations in which the private organization participates in the decision-making along with the government as well as the production of a public good or service that has traditionally been provided by the public sector and in which the private sector also shares the risk of that production (Forrer, et al., 2010).

Indian government has also defined public-private partnerships rather broadly more than a decade ago. The Task force on public-private partnerships, constituted by the GOI, defines 'Partnership' as,

> "a collaborative effort and reciprocal relationship between two parties with clear terms and conditions to achieve mutually understood and agreed upon objectives following certain mechanisms" (MoHFW, 2012, p. 3).

This aligns with how WHO defines a partnership in the healthcare sector; according to them the purpose of PPPs is to bring together a set of actors whose common goal is to improve the health of populations and they do so on the basis of mutually agreed roles and principles. (Kickbusch & Quick, 1998). The key principles behind partnerships in the healthcare sector are maintaining balance of power and influence between the partners, mutual respect and trust between them, transparency and shared benefits (Ibid).

India has experienced considerable growth in PPPs in the last one and a half decades making it one of the leading PPP markets in the world (DEA, 2011). As several states engage in a rage of PPPs across different sectors, it was necessary that a more bracketed and unambiguous definition of PPP exists in the policy ecosystem in India. To this end a Draft National Public-private Partnership Policy was released by the Department of Economic Affairs of Ministry of Finance. It defines a PPP as;

> "An arrangement between a government/statutory entity/government owned entity on one side and a private sector entity on the other, for the provision of public assets and/or public services, through investments being made and/or management being undertaken by the private sector entity, for a specified period of time, where there is well defined allocation of risk between the private sector and the public entity and the private entity receives performance linked payments that conform (or are benchmarked) to specified and pre-determined performance standards, measurable by the public entity or its representative." (DEA, 2011, p. 4)

Key components of this definition are:

- Either investments should be made by the private sector or/and management of the partnership should be undertaken by the private sector entity.

- The central focus is on performance and not merely provision of facility or service, hence the clause of performance linked payments.
- Conformance to performance standards pre-defined in the agreement is necessary, the focus is on the aspect of service delivery along with compliance with pre-determined and measurable standards.

In addition to these 'essential conditions' the report also prescribes a list of 'good practices' for PPPs such as an incentive or penalty bases structure to ensure that the private partner meets the service benchmarks, outcomes of PPPs to be defined as output parameters and not as technical specifications such as assets to be built or machines to be installed etc. However, as the chapter on PPPs in Bihar will show, several of the essential conditions as described by the MoF report are not abided by while undertaking a PPP in the healthcare sector in Bihar; to expect them to follow some of the good practices seems like a wishful thinking.

However, as the boundaries between the political and the economic is not static; the nature of partnerships also changes over time and the PPPs that exist today would cease to be called partnerships if they are to be judged on many of these parameters. The most basic conflict lies in what each partner desires from a partnership. While for the private and non-state entities, it is the pursuit of profit, for the state, it is welfare and providing healthcare to its people. Rosenau has also questioned the growing consensus in policy literature on the claim that PPPs can combine the best of both the public and private sector. She argues that if cost reduction or profit maximization that PPPs emphasize upon, happens at the price of significant quality compromises, vulnerable populations may not be able to respond appropriately and would be marginalized from the benefits of the partnership, which will effectively mean the failure of such partnerships themselves (Rosenau, 2000). The reduced cost argument of PPPs has also been challenged by some researchers. They argue that a lot of effort goes into conceptualizing, materializing and implementing a successful partnership; such partnerships are not created overnight, but are developed over time by people working together to build a robust, open and trusting relationships (Foster & Sturgess, 2005). Therefore, if one includes the non-financial as well as the financial costs, partnerships are expensive to create and maintain and they must have a real and significant goal or purpose that neither of the partners cannot achieve individually (Ibid).

Public-private partnerships in health raise very important ethical questions on the role of the private sector in public health. Where does the ultimate responsibility of ensuring health and

well-being lie? Can private enterprises be awarded rights similar to individuals, and if such rights are accorded to them then how will accountability and responsibility be fixed? How will social justice and profit accumulation co-exist? What role the state would play; of a regulator, provider or facilitator of services? These questions have no clear answers, but the positive change claimed to be brought by PPPs is yet to be demonstrated with evidence. Despite the scale and significance of the phenomenon, there is relatively limited conceptualization and in-depth empirical investigation. Their advocates argue that partnerships can offer better-quality infrastructure and services at 'optimal' cost and risk allocation (Kwak, et al., 2009). The assumption at the base of all PPPs is that the state doesn't have the resources or the capability (technical/managerial) to deliver many public goods and services that it earlier used to (Forrer, et al., 2010). Public Health scholars have often raised the concern that in their eagerness to address market failures and pursue international public goods PPPs are often structured so that the public sector absorbs the lion's share of the risks and costs, while the private sector absorbs a disproportionate share of the profit (Buse & Walt, 2000).

One issue with academic as well as policy literature around PPPs in healthcare is that in most cases, all types of contracts or outsourcing is considered as a PPP. There is a tendency to dub any type of combined public-private effort as a PPP, however, as academic literature shows, there is an overarching agreement across witters about certain basic characteristics of a public-private partnership. The range of projects described as 'public-private partnerships' in India as well as globally is enormous; when looked closely many of them are just subcontracting mechanisms (Schaeffer & Loveridge, 2016). In fact, my field work showed healthcare workers perceived PPPs to be contracts and outsourcing arrangements only. They would refer actual PPPs as 'technical support programs' or by the name of the partnership but not consider it to be a PPP. It was especially true if an external funding agency was the partner. Even though there are a lot of variations in terms of defining PPPs and what constitutes PPPs; sifting through some of the most cited ones and attempting to coalesce some basic features that could be used to define public-private partnerships, following are some of the essential criteria. As it had been argued by Kickbusch and Quick in a world health quarterly report, it's important that some key principles in partnership building are agreed upon because there are bound to be definitional variations (Kickbusch & Quick, 1998).

- Partnership is implemented for the providing public good or service for public benefit.[6]
- Risk sharing with the private sector is an integral component of a PPP; **therefore, merely outsourcing contracts for specific services are not PPPs.**
- Similarly, both partners should benefit proportionally from the partnership.
- Both partners work towards a shared goal/s.
- **PPPs are long term agreements.**

Kent Buse and Gill Walt have taken the role of international agencies into consideration and come up with a definition that is more suitable to modern day needs. They define Partnerships as a collaborative relationship amongst at least three parties; a corporation/industry association/ private enterprise, a government/statutory body and an intergovernmental/multilateral organization. These partnerships can transcend national boundaries in order to achieve a shared 'health-creating goal on the basis of a mutually agreed division of labour' (Buse & Walt, 2000, p. 550).

3.2.1 Neoliberal PPPs in Health: When and Where do they begin

Partnership or collaboration between the government or a public sector entity with the private is not a new phenomenon; governments have been using private individuals as well as enterprises to deepen the reach of its services, to increase public awareness, to increase faith in new interventions etc. However, the origins of modern PPPs that have spread after the proliferation of neoliberal ideas may be traced back to the British government's public policies in the 1980s. The present version of PPPs, in which the private organization is paid by the government rather than by customers, was created by the Thatcher government. Reforms introduced by the Thatcher government revered the welfare policy that the country had relied on for decades in provisioning of public health. Public services that address basic human needs have been converted into free market commodities. This was done to the detriment of welfare states in the industrialized countries. The introduction of neoliberal fiscal rules was aimed at the reduction of public expenditure and public borrowing. However, democratic compulsions meant that governments still had to make some investments in public infrastructure and

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[6] 'Public Services' are those services that the State is obligated to provide to its citizens or where the State has traditionally provided the services to its citizens. 'Public Asset' is that asset the use of which is inextricably linked to the delivery of a Public Service, or, those assets that utilize or integrate sovereign assets to deliver Public Services.

services . In fact, in the beginning, PPPs in the UK were designed as a novel accounting solution for a public finance problem. The neoliberal fiscal constraint on borrowing led the government to look for private investments through the Public Finance Initiative (PFI) route. As the accounting rules allow them to be treated as private borrowing, not public borrowing; the money could be borrowed without breaching the fiscal rules (Pavanelli, 2015). For the private partners involved, PPPs represent an extremely attractive business opportunity. A single contract can give them a steady flow of business for years and at many times decades, underwritten by the governments themselves.

> "PPPs originated as an accounting trick, a way round the government's own constraints on public borrowing. This remains the overwhelming attraction for governments and international institutions. Just as companies like Enron had tried to conceal their true liabilities by moving them 'off-balance-sheet', so governments started using PPPs as "tricks…. whereby public accounts imitate the creative accounting of some companies in the past." (Hall, 2014, p. 7)

Even though the use of public-private partnerships in the health sector is seen as widespread in the present global health landscape, it has been subjected to extremely polarizing debates academically. Several of the arguments in favour as well as against the use of PPPs have their roots in the debates about the role of private sector in the health sector.

3.3 Arguments in favour of PPPs:

PPPs have been promoted as an important development financing mechanism in support of the Sustainable Development Goals (SDGs). SDG 17 outlines a vision for partnerships between governments, private sector and civil society, and delineates these as "inclusive partnerships built upon principles and values, a shared vision, and shared goals that place people and the planet at the centre, are needed at the global, regional, national and local level" (United Nations, 2015, p. 1) It is argued that PPPs have the capacity to deliver high-quality services to consumers and the government at significantly lower cost, which would be impossible for public investment and government provision to provide (IMF 2004). Government of India argues that PPPs can "harness private sector efficiencies in asset creation", bring more "innovation and technological improvements" as part of the private sector practices and "enable affordable and improved services to the users in a responsible and sustainable manner" (DEA, 2011, p. 8). Others who favour PPPs also argue that they have the ability to fill the gaps that are left out by the public as well as the private, benefiting from the strengths of each other. Private partners

can bring their intellectual superiority, business efficiency and management principles and the public sector can provide for the resources or the provisions to utilize that expertise (Reich, 2002). Additionally, it is suggested that working with private sector companies may allow public sector organizations to access idiosyncratic resources and capabilities in seeking to realize more innovative responses and, for instance, improved health services quality (Kivleniece & Quelin, 2012). For-PPP arguments are also based on the claim that by promoting increased diversity of provision and contestability, partnerships are in a position to provide better quality services and infrastructure at optimal cost minimum risk (Kwak, et al., 2009). A year before demitting her office as the Director general of the WHO, Harlem Brundtland, one of the staunchest advocates of the partnership model in the health sector, stated that the complex health problems of the world cannot be solved by WHO alone, cannot be solved by governments on their own, NGOs, the private sector and Foundations can also not solve them alone. Only through innovative partnerships can these health problems be solved and the goal of health for all be achieved (Brundland, 2002). Brundtland's views goes on to show the extent to which pro-PPP ideas had a stronghold even at the top management in the world's oldest and largest multilateral health institution. However, the theoretical and empirical validity of these assumptions needs further analysis as they are not evidence based (Richter, 2004). Venkatraman and Bjorkman have agreed to Brundtland's characterization of the nature of issues that are prevalent in the health sector and concur that "neither the public nor the private sector alone can achieve desirable health outcomes" (Raman & Björkman, 2015). They also argue that PPPs have the ability to strengthen both the public as well as the private sectors in mutually beneficial ways.

However, there is a paucity of comprehensive evaluation and research on the efficiency and effectiveness of PPP models in the delivery of healthcare services when compared to public supply. Because PPPs are often long-term arrangements, they are influenced by changing political, social, economic, and technological settings. They're also complicated, needing a high level of confidence, political will, and contracting skill to balance risk and profit for all parties. Due to a lack of a defined regulatory framework and confidence between partners, many PPPs have had little success. Furthermore, while PPPs are frequently used to remedy access, quality, and efficiency deficiencies that the public sector cannot address through its own structures, contracts are frequently vague (NITI Ayog, 2019). There is a clear lack of empirical evidence, despite decades of PPP advocacy on how exactly these programs are more efficient vis-à-vis public provisioning or to what extent they reduce the financial risk for the state exchequer.

Health economists have also failed to come up with an evaluation framework to assess the efficiency of such partnerships or their cost to benefit ratio. The financial benefits of choosing a PPP route have been reported in the TB control program in South Africa (Sinanovic & Kumaranayake, 2006). According to a comparative cost vs performance analysis of public hospitals versus public-private partnerships hospitals in Spain, it was seen that the PPP group obtained good results in some areas, above the average for those directly managed by the government, but they were not better in every case. Therefore, the results were not considered conclusive enough to clearly opt for one model of management; in both cases strengths and weaknesses were identified (Ibid). Health policy is becoming increasingly reliant on assumptions and pro-private rhetoric rather than unambiguous evidence on how such partnerships are better than the public provisioning of healthcare. The enthusiasm for experimenting with and scaling up PPP models in healthcare delivery falls short of the lessons that have been learnt across the world in a variety of socio-economic settings.

3.3.1 Critiques of PPPs:

Debates around the suitability of public-private partnerships in public services in general and public health in particular raise some very critical questions regarding the distinct characteristics of the public and the private sector. Most often, various stereotypes dominate these debates; the public sector is seen as bureaucratic, monolithic, inefficient and wasteful. Whereas, the private sector is generally seen as efficient, innovative, efficient and lean. In a Briefing Paper by Birbeck University, Eurodad (European Network on Debt and Development) and Latindadd (The Latin American Network for Economic and Social Justice), arrived at a set of three conclusions on a basis of the global evidence on PPPs on the health sector:

- Health PPPs can be expensive and a risky proposition.
- There is no empirical evidence to claim that PPPs deliver positive health outcomes.
- Health PPPs ***can have negative impacts on the wider health systems*** (Birbeck; Eurodad, Latindadd, 2019).

Critiques of PPPs look at is as another form of marketization of healthcare and argue that these stereotypes are not based in evidence and that in fact the public sector is reliable or dependable, it is equitable and fair and the private sector is unjust, self-serving and profit driven (Powell & Miller, 2014). Public Health scholars have often raised the concern that eagerness to address market failures with market forces public-private partnerships are often designed in such a way

public sector ends up absorbing a larger share of the risks and costs, while the private sector gains a disproportionate share of the profit (Stansfield, et al., 2002). Some authors argue that public sector organizations often assume sub-ordinate roles in PPPs which may trap them into post-contractual 'lock-in situations' considering the length of these contracts (Lonsdale, 2017). The potential of PPPs in healthcare leading to unequal standards of care in public and private sectors has also been raised by researchers (Bhat, 2001). Reliance on PPPs often weans resources away from the public sector, which means that slowly the public health system weakens and the quality of care starts to become worse. On the contrary, the private sector, buoyed by the additional revenue source from a captive market gets a chance to improve its services and attracts more customers, often from the public sector (Ibid).

Critiques of PPP also argue that they are a part of the growing trend of 'welfare pluralism', a philosophy that believes in increasing private financing and provisioning in social sectors. This liberalization of welfare measures creates and fosters markets in previously state dominated public services (Birch & Siemiatycki 2006). The criticisms of PPPs, however, have not dented the ways large international organisations view their potential. One of the most apparent disadvantages of the public-private partnership model is the obfuscation in roles and responsibilities of different actors in the global health arena. UN agencies, governments, multinational corporations, philanthropic foundations and NGOs are all called 'partners'. The fact that these actors have different and possibly conflicting mandates, goals and roles has been lost in the present context (Richter, 2004). The prodigious and uncritical welcome that United Nations and its health agencies like the WHO and the UNICEF have accorded to PPPs have been seen as dangerous trends by global public health activists (Velásquez, 2014). Brundtland's open declaration in the world health assembly in 2002 that basically meant that there was no global public health without PPPs marked a clear shift in WHO's strategy. However, it was also interpreted as a threat to the democratic, multilateral functioning on which the United Nations system the WHO are based (Ibid).

Partnerships are also criticized by health activists and researchers for diverting public resources and in the process distorting public agendas in ways that will favour private companies. Any partnership essentially means equitable sharing of objectives, efforts and benefits, essentially an equitable sharing of power. However, the role of the government in a PPP raises serious doubts about the balance of power. Nevertheless, the most obvious incongruity lies in the objectives of the government and the private entities, government's objective is to ensure social

justice (at least ideally) and the private company's objective is to make money. In addition, most often-social justice does not contribute to accumulation of profits for a few. In addition, governments have to be regulators as well as partners, which is a very tight rope to walk. How does one facilitate and regulate at the same time?

Some authors also argue that in contexts where the state capacity is limited, like in several low-income countries, the public sector often becomes a sub-ordinate partner in PPPs, and considering the length of these agreements, it might find itself in a post-contractual 'lock-in situations' with no option but to continue (Lonsdale, 2017). PPPs are also criticized because of their focus on cost minimization; as private companies are mainly remunerated for successful delivery of services, they design their incentive structures in such a way that it promotes cost minimization, even at the cost-of-service quality deterioration (Grout, 2008). These concerns and criticisms are extremely important when studying public-partnerships in the context of states like Bihar where the governance structure, its managerial capacity and regulatory systems are poor. Somewhat ironically, given that their avowed purpose is to access the additional capabilities of the private partners, several research studies note the problematic impact of asymmetric skills between public and private actors (Dixon, et al., 2005). While public actors were found to have limited abilities to engage in strategic planning with private actors, private actors have been criticized for their purely commercially driven outlook of public-private partnerships (Ibid). Public-private partnerships should not and cannot be an alternative to poor governance and leadership, on the contrary, the success of a PPP depends upon a strong and able state (Ghanashyam, 2008).

The PPPs in health were initiated based on the assumption that they create a "win-win" situation for both partners (Raman & Björkman, 2015). This assumption of a "win-win" situation contributed to the rapid increase in the number of health PPPs without clear mechanisms for evaluation or evidence of their effectiveness viz-a-viz the state-led model of healthcare. If everyone wins there should not be too much danger, however, if in these alliances there are "winners" and "losers" one must evaluate who wins and loses what. A private partner stands to gain a lot more than what is tangibly laid down in their partnership agreement in terms of the monetary compensation. Gleaning from the arguments in the previous sections, some of the often-underrated benefits that a private partner could derive out of a partnership with a government/government agency are:

- Private players using government to gain health information for their own marketing benefits.
- Private players also get legitimacy and are looked favourably if they are in partnership with the government. This enhances their brand value.
- There is a captive market that comes with a partnership with the government. The steady flow of customers is coveted by any private enterprise.
- For the public sector also, such partnerships come at some unspecified risks. Governments lose their power as a regulator once they become partners with certain private agencies.

Generally private sector stands to gain more from a PPP compared to the other partner i.e., the government. Until a partnership is consciously designed in such a way that it protects the interests of the public, it is unlikely that the government is a greater or an equal beneficiary. States with weak public health infrastructure or states that depend largely on the private sector for providing healthcare are at a greater risk of being in an unequal partnership.

3.4 New Management Principles: Administrative mainstay of PPPs

The popularity of public-private partnerships in the healthcare sector was also driven by the emergence of an alternative framework of New Public Management (Yescombe, 2011). NPM was founded on the belief that private-sector management approaches were vastly better than the bureaucratic principles of public administration (Skietrys, et al., 2008). In essence what the NPM approach strives for is to introduce market like behaviours into public services.

Key elements of these reforms included decentralization of public services, increasing use of market principles like increased competition, contracting-out of services, introduction of user charges for availing public services etc and increased emphasis on productivity and cost-efficiency (Larbi, 1999). These reforms were collectively known as the New Public Management principles and at their heart they strove for a state limited itself to regulation, stewardship and purchasing rather than service provisioning (Bately, 1999). The basic premise of New Public Management was that the management practices and techniques of the private sector, its fiscal discipline and orientation towards consumer needs are far more superior to the public administration techniques. Various forms of the NPM reforms were seen as a panacea for the crisis of the welfare state model. In developing countries like India, these reforms were driven by donor countries and development banks as part of the structural adjustment policies

(Larbi, 1999). As part of the lending conditionalities, developing countries were dictated to introduce these reforms in their economies.

New Public Management has come to be known as a set of largely similar administrative reforms that most of the developed countries undertook in the 1970s to overcome the fiscal crisis. It has been defined as an ideology or a strategy or a set of management approaches and techniques mainly borrowed from the private for-profit sector to be applied to the public sector and the state-owned enterprises (Flynn, 1993). The old model of public service organisation and delivery, based on bureaucratic hierarchy, planning, centralization, direct control, and self-sufficiency, appears to be being supplanted by market-oriented public service management. According to a survey of the NPM literature, it is not a single entity, but rather a collection of characteristics that describe trends in public management reform in developed countries. The main goal of NPM reforms was to improve the way government is run and services are delivered, with a focus on efficiency, economy, and effectiveness.

NPM conformed to the neoliberal belief that economic efficiency can only be attained and the people afforded free market choice through market competition. It was argued that the market is an effective resource allocator, an efficient coordinating mechanism, and a logical decision-making process while praising the virtues of the market. Changes were required in the quest for government efficiency and effectiveness and adopting management strategies, practices and techniques employed by the private sector to address the challenges of the old public administration, i.e., private sector remedies were sought for public sector problems (Larbi, 1999). Not only were changes necessitated in the quest for government efficiency and effectiveness, but the adoption of private sector management techniques and practises were also hailed to address the challenges of the old public administration.

Entire gamut of the NPM reforms can more or less be summarised in one sentence; seeking private sector remedies for complex public sector problems. Apart from the development finance institutions, export of the NPM template from developed to developing countries was led by agents such as international management consultancies. They have played a critical role in packaging, selling, and implementing NPM concepts, as state actors seeking institutional change or strengthening frequently hire professional consultants to clarify alternatives and provide recommendations (Saint-Martin, 1998). Taking the ‘government bad’ and ‘private good’ stance, these NPM advocates argued that the dividing line between public and private sectors will diminish or be blurred and the same good management practices will eventually

prevail in both sectors (Ibid). The raison d'etre of NPM reforms; that the public sector is inefficient, rigid, unresponsive and wasteful and that the infusion of market type mechanisms along with the remodelling of the state as a provider to state as a purchaser and regulator, is also the foundation on which PPPs stand.

3.4.1 Privatization to PPP

Even though the neoliberal strategy for market expansion has espoused the PPP route over privatization, the fundamentals seem to remain unchanged. When one compares the global narratives that extolled increased privatization of healthcare and freeing the health sector from an inefficient state that was omnipresent in the global health policy discourse throughout the 1980s and the 1990s to the strengthening global narrative that have gained prominence in the past two decades, the two are eerily similar.

- Both were espoused by global financial institutions and donors.
- Both were the preferred routes to provide aid for philanthropic foundations.
- Both these narratives are unambiguous in their support for the increased marketization of healthcare.
- Both treat healthcare as a commodity, assume that issues in public health are uncomplicated enough to be solved by employing business principles and practices.
- The same virtues and vices of the private and the public sector that were cited in favour of privatization are also being cited in favour of PPPs
- Management consultant played a critical role in defining the epistemological landscape of privatization of healthcare as well as PPPs.

3.4.2 Is there some evidence that PPP are a smarter choice?

Private Sector Efficiency, Value of Money and Shared risk and rewards are the three themes that are predominantly present in most of the PPP guidelines. Government's Task Force on PPPs recommend that all partnerships should meet at least two basic criteria, namely value for money and clearly defined sharing of risks (MoHFW, 2012). A discussion paper jointly prepared by the WHO, ADB and UNECE argued that value for money and private sector expertise along with increased funding on healthcare by countries are two of the key drivers of PPPs in the health sector (WHO; UNECE, ADB, 2002). The ADB in its PPP handbook also notes that the public sector generally lacks financial and operational discipline, which are

present in the private sector. If PPPs are designed in a such a way that the private sector is allowed to pursue its goal of profit maximization, efficiency of services under the PPP is likely to be improved (ABD, 2014). Value for money is a central concept in PPPs. The OECD guidelines for PPPs mention that the primary reason to implement PPPs is to improve service delivery, which means creating greater value for the same amount of money compared public provisioning of services (OECD, 2008). Others have also argued on the same lines, proposing that the better quality of services offered by a private partner under PPP compared to public provisioning of the service actually means that the PPPs offer more value for money (Kivleniece & Quelin, 2012). According to the World Bank;

> "Private sector actors in PPPs can use their management skills and capacity for innovation to improve efficiency and quality standards. Efficiency gains play an important role in increasing value for money through PPPs" (World Bank, 2015, p. 6).

Government of India also argues that PPPs can 'harness private sector efficiencies in asset creation, maintenance and service delivery' (DEA, 2011, p. 8). Sharing risks and reward fairly is also one of the key features in the PPPs definitional literature. The OECD guidelines on PPPs argue that to ensure efficiency and value for money, sufficient transfer of risk from the government to the private partner is necessary. However, it also maintains that the public sector is not only responsible for transferring risks to the private sector but it must also support the private sector with both financial and non-financial means (OECD, 2008).

The claim that private sector can achieve better results at lower costs has been challenged and often refuted by evidence-based studies. Private participation in health care is often found to be associated with higher expenditures. Costs increase as private providers pursue profitable treatments rather than those dictated by medical need. Increased privatization of healthcare has led to a decline of less-profitable preventative health care in many countries. Inefficiencies also arise from the difficulty of controlling and regulating private providers, particularly where government capacity is limited and there are too few private suppliers to assure price competition. A report by the United Nations Research Institute for Social Development published in 2004 analysed data from 44 middle and low-income countries and suggested that higher levels of private-sector participation in primary health care was associated with higher overall levels of exclusion of poor people from treatment and care, especially women and girls (Mackintosh & Koivusalo, 2005). The cost-efficiency case of PPPs is further weakened when one takes into account the source of capital in PPPs, which is in moist cases public finance. An

analysis of the National Health Service (NHS) of Britain argues that public finance is cheaper than private; even when governments borrow, the rate of interest on these borrowings is lower than the market lending rates. Therefore, factoring in the lower interest rates, PPPs are actually not as cost-effective as they are claimed to be (Hellowell & Pollock, 2009).

Similarly independent scholars have also argued that PPPs can provide a more diverse set of services at optimal cost and risk allocation (Kwak, et al., 2009). However, a contrarian view has also argued that it is the public sector that ends up incurring major share in the overall risks and costs associated with a partnership, while the private sector absorbs a disproportionate share of the profit (Buse & Walt, 2000). Several scholars have rejected the value for money rationale, arguing that several other cost heads such as training and supervision, capacity building and use of public health infrastructure by the private sector actually undercounts the real cost of these partnerships and without a detailed cost-effectiveness analysis that includes all direct and indirect costs, the argument that PPP add more value than the public sector is not evidence based (Baru & Nundy, 2008).

The assertion that PPPs lead to equal sharing of risks has also been refuted. A systematic review of case studies, reviews, case-control analyses and reports published by non-governmental organizations and international agencies was conducted by Sanjay Basu and others reported that the available research did not support the claim that the private sector is usually more efficient, accountable, or medically effective than the public sector (Basu, et al., 2012). Further, the review found that in low- and middle-income countries, public provisioning of healthcare was more cost efficient compared to the private. Inefficiencies in the private health sector in these countries were caused by the incentivization of unnecessary testing and treatment, violation of standards of practice leading to poorer health outcomes and higher cost of medicines and diagnostics (Ibid). public sector in these settings were often found lacking on timeliness and behaviour towards patients (Ibid). While PPPs are often advocated as the best alternative model that governments can look up to as they are constrained by their own lack of resources, it is clear that the need to rely on the private sector stems from the fact that neoliberal policy reforms have resulted in a sharp drop in government revenue in many countries, undermining state capacity to deal with health issues and distributive justice issues. despite several years of a burgeoning pro-privatization agenda both in high income as well as low- and middle-income countries, hard evidence to support these assumptions were found wanting.

3.5 Global agents promoting PPPs

The big push for PPPs came from the OECD countries, advocated by change agents like management consultants and multilateral banks through the NPM route. State agencies contemplating institutional change or strengthening systems often enlist the services of management and accountancy consultants, who have been instrumental in the inclusion of new management techniques from the private into the public sector (Greer, 1994). They have played an important role in packaging, selling and implementing NPM techniques (Ibid). The public-private partnership model of health has also been endorsed by several global agencies associated with public health. International aid agencies and foundations (USAID 2002, DFID 1999, IMF 2004) mostly fund available literature advocating the need for PPPs. They are symptomatic of the ceding of authority of the state to the private sector since the fall of the welfare states. Partnerships between the private and public sectors in the health sector was minimal until the 1980s, and participation was generally limited mainly to the realm of political consultations with non-governmental organizations (NGOs). Most of the development aid for health came from two sources: international development banks such as the World Bank and the IMF, and bilateral programs from donors. However, under the overarching influence of neoliberal global economic policies as well as the specific managerial backing of the tenets of the New Management Principles associated with neoliberal ideology, the relationship between the private and public sectors began to change. International lending agencies advocated a greater role for the private sector to collaborate in health-related development projects. Initial calls for changing the conventional paradigm of public procurement sprang from worries about the extent of the public debt, which increased quickly during the macroeconomic upheaval of the 1970s and 1980s. Governments all throughout the world were concentrating on innovative methods to finance initiatives, develop infrastructure, and provide services in a cutthroat global context.

Multilateral development finance institutions expressly enunciated that they would rely on the PPP route when funding projects. The Asian Development Bank (ADB) in its strategy paper published in 2008 mentioned their major strategy as emphasizing on the promotion of PPPs in all of ADB's core operations. The document titled 'Strategy 2020' recognised private sector growth and activities as the main forces behind change in Asia-Pacific region, and PPPs were seen a crucial instrument towards this end (ADB, 2008). The bank's present lending programs are designed to subsidise, support and promote PPPs across a number of debtor countries. The

Inter-American Development Bank has also set its strategic goal as promoting development through the private sector strategies including PPPs (IDB, 2010). Rather candidly, the IDB acknowledges that PPP is one of the components of the private sector expansion strategy (Ibid). All other multinational development banks, namely the European Investment Bank, the African Development Bank and the European Bank for Reconstruction and Development have PPPs as one of their core strategies to promote and expand private markets in previously state dominated sectors (IEG, 2012). At the 2010 UN MDG summit, eleven donor countries and agencies that included DFID, USAID, SIDA, Ministry of Foreign Affairs of the UK and Finland, declared that 'the private sector is the engine of economic growth and development' and that they 'will enter into partnerships with local and international companies of various sizes' on key development issues (UN, 2010, p. 1).

The ideas of Global Health Partnerships also took form at the beginning of 2000s and public-private vaccine alliance, GAVI was launched at the World economic Forum at Davos. Its founding members included The Bill and Melinda Gates Foundation, the Rockefeller Foundation, the International Federation of Pharmaceutical Manufacturers' Associations, UN agencies (WHO, UNICEF), the World Bank, and some national governments (US, UK, Norway, Netherlands). The Global Fund to Fight AIDS, Tuberculosis and Malaria, popularly known simply as the Global Fund, was also established in 2002 as an innervational funding mechanism with the aim of quickly raising and allocating cash for initiatives that lessen the effects of HIV/AIDS, TB, and malaria in low- and middle-income countries (Hanefeld, 2014). It was set up as a collaboration between high income countries, business, civic society and impacted communities in low-income countries along with their governments (Ibid). An ever-greater variety of private foundations and philanthropists, NGOs, and for-profit enterprises then joined and at times overtly challenged, the conventional actors on the global health stage, most notably national ministries of health and the WHO (Szlezák, et al., 2010). However, one agency whose role stands out prominently in the past growth of PPPs in health as well as in its current landscape is the World Bank Group. The new World Bank Group Strategy adopted in 2013 declares that the group "will increasingly promote public-private partnerships. Such partnerships can contribute to improved basic service provision in areas such as health, education, sanitation, and housing that are essential for reducing poverty and boosting shared prosperity" (WBG, 2013, p. 20). The group consists of four organizations, namely, the International Bank for Reconstruction and Development (IBRD), the International Development Association (IDA), the International Finance Corporation (IFC), and the

Multilateral Investment Guarantee Agency (MIGA). The large-scale lending that the group undertook in the wake of the global economic crisis of the 1980s, placed it uniquely to influence, steer and sometime even dictate the economic policies of debtor countries. The academic foundations of PPPs were also strengthened by the Bank through a series of research and policy reports over the years.

3.5.1 World Bank and its pivotal role in propagating partnerships in health

World Bank is one of the largest funders of health programs in developing countries including India. However, direct lending for health projects was not a part of the Bank's strategy until 1975, except for the population projects that it started investing since 1970 (World Bank, 1980). The Health Sector Policy Paper 1975 was its first policy document dedicated specifically to health. With the first formal health sector policy paper, World Bank declared its intent to be more involved in global health. The report criticized health systems in less developed countries for being top-heavy and focussing too much on tertiary care in urban areas ignoring the health needs of rural populations. It recommended that health policy should be focussed on extending the coverage of primary healthcare, which is close to the community it serves it was unequivocal in arguing against the failure of private markets in the health sector and the need for active government intervention to minimize the risks.

> "The private market cannot be expected to allocate to health either the amount or the composition of resources that is best from a social perspective. The most critical failure of the market derives from the inability of consumers of health services to choose rationally. This inability is in part a consequence of the extraordinary complexity of medical problems and the consumer's lack of experience as a patient" (World Bank, 1975, p. 29)

Highlighting the link between inequality and health, it goes on to say that;

> "While the distortion caused by income inequality applies to all sectors, the consequences for health are particularly tragic" (World Bank, 1975, p. 31)

In view of the above-mentioned risks, it asked for comprehensive government control and intervention in the area of public health (Ibid). With the second health policy paper published in 1980, WB reviewed its strategy to be involved directly in health projects and decided to pursue it further by lending for projects specific to health in addition to financing projects that

had health components in the past (World Bank, 1980). Most of the observations and recommendations in his paper were replicated from the Policy paper of 1975. Both documents recognized that one of the problems in developing countries were excessively focussed on curative care though large hospitals and were ignoring preventive and primary healthcare services. Designing and implementation of health policies were recognized as bigger obstacles than lack of technical and financial resources. However, this was the first time when the issue of user charges was discussed by the Bank in the 1980 paper. Although it did not recommend user charges in public health facilities, the paper presented it as an option that some low-income countries resort to;

> "To discourage overutilization of services, a few countries require a small registration fee from patients presenting a problem for the first time… User charges are unpopular with governments because of the high cost of their administration arid widespread problems of misappropriation of cash by health workers" (World Bank, 1980, p. 19).

However, in the 1980s, the Bank undertook a series of lending in debt and deficit ridden developing economies. This period is also witnessed a marked deviation in its approach towards healthcare issues in developing countries.

In a 1987 report titled 'Financing Healthcare in developing Countries', it advocated four policy reforms to improve healthcare in developing countries: (i) Introduction of user charges in government health facilities, (ii) health insurance schemes to cover cost of care, (iii) increased participation of for profit and non-profit private players, (iv) Decentralization of government health services; purchasing of services from the market and use of market incentives in allocation.

These recommendations run contrary to the Bank's health policy of 1975 and 1980. The reasons for this paradigm shift lie in a set of macroeconomic policies that the Bank enforced on borrowing countries throughout the 1980s and 1990s. These policies required withdrawal of the state and opening up of markets in several sectors to reduce government expenditure and increase private investments. In the early stages of neoliberal policy development (during the 1980s), most development actors advocated liberating the market from government control. The 1993 World Bank report was instrumental in establishing the World Bank's dominance over the WHO in global health policy-making and challenged the dominance of the public sector by facilitating greater private sector participation. It was the first World Development

Report (WDR) that was dedicated entirely to health (World Bank, 1993). The World Health Organization (WHO), which remained the leading World Health Organization until the early 1990s, was replaced by the International Financial Organization (IFI), particularly the World Bank and IMF, as the central coordinating body for global health policy (Abbasi, 1999). The report identified four major problems with the health systems in less developed countries like India, they were ***misallocation, inequity, inefficiency and exploding costs***. (World Bank, 1993, pp. 3,4). It argued that financial allocations in such countries were not cost-effective and were skewed towards high-cost low yield services like teaching hospitals ignoring low-cost interventions like TB. It also argued that most cost-effective interventions could be best delivered at lower-level healthcare facilities; insinuating that it recognized the importance of the primary healthcare model. It further argued that the underprivileged populations "lack access to basic health services and ends up receiving low-quality care…government spending for health goes disproportionately to the affluent in the form of free or below-cost care in sophisticated public tertiary care hospitals and subsidies to private and public insurance", making the health system highly iniquitous (Ibid, p. 4). *The report also stressed how wasteful and inefficient the public health system was in developing countries. However, when it came to recommending solutions to overcome these four challenges, the WDR 1993 relied heavily on advocating the restricted role of governments in providing healthcare.*

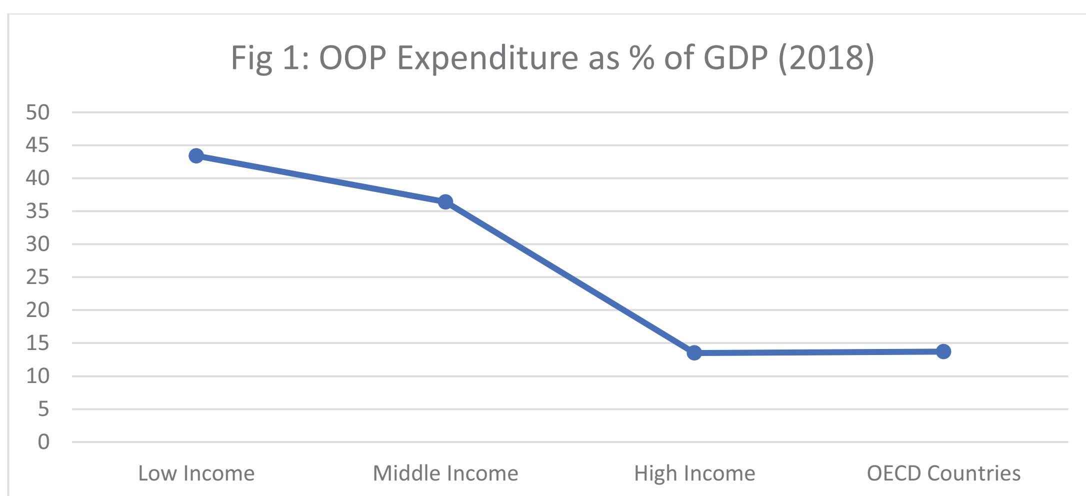
Despite evidence of healthcare becoming more expensive and inaccessible as a result of these charges, it argued that these charges in-fact help the poor the most as hospitals can introduce new facilities with the additional income generated from the charges.

It categorized health services in two ways: Public health programmes that are population-based health services. The report recommended that the government should restrict itself in running public health programmes and providing a carefully selected package of public health services depending upon the disease prevalence and health status of the country. While it should facilitate private health providers, both for and not for profit to provide most of tertiary care services. It further recommended that government should desist from investing in tertiary care hospitals, instead. It also recommended that governments should restrict itself in providing health services that are 'public goods' and that have large externalities, i.e., services where an individual's behaviour affects others. The report endorsed the idea of selective primary healthcare, which meant that governments in resources constrained economies should focus on

providing a package of essential primary healthcare services like sick-child care, family planning, prenatal and delivery care, and treatment for tuberculosis and STDs.

World Bank's advocacy for increased private participation in healthcare was drawn out specifically in WDR 1993. It recommended 'scaling back' of government run health systems in developing countries and the idea was accepted and disseminated by governments that were unwilling to increase investments in public health systems but wanted a quick-fix for their immediate health needs (World Bank, 1993). Indian economy that was heavily dependent on international aid after the balance of payment crisis of 1989-1990 became ideal cases for the finance institutions to test their newly devised pro-market tenets.

All such sweeping recommendations completely overlook the fact that private health financing is now generally accepted to be regressive, meaning that if it is the primary way of obtaining health care throughout the social spectrum, it disproportionately affects low-income individuals and excludes the very poor. Out-of-pocket spending is the most regressive of all, and it is the population of several low and middle-income nations, such as India, that suffer the most from this barrier to health-care access. Evidence shows that even in high-income countries, commercialised healthcare is not a preferred system. The global Out of pocket expenditure data, when analysed according to the income category of countries clearly shows that wealthier countries rely less on privately financed healthcare (Figure 1) (WHO, 2019).



Source: The World Health Organization: Global Spending on Health report

By the late1990s, the global quest for full privatization of health care was abandoned, even by some of the most zealous advocates of neoliberal solutions to global health problems, including the World Bank. However, the World Bank continues to perform the same role it had during

the privatisation process. The most straightforward way is to impose conditionalities to its projects, requiring governments to adopt PPPs in order for money to be made available for infrastructure. The Public-private Infrastructure Advisory Facility (PPIAF) was set up by the World Bank along with the ADB in 1999 with the aim to provide grants to countries to:

- Development of markets, policy and regulatory systems as well as operational processes to increase private participation in infrastructure.
- Capacity building of government contracting departments and authorities
- Improving the creditworthiness of public institutions to increase the financing potential of partnership contracts.
- “Supporting pioneering PPP transactions in fragile countries and sub-sovereign financing”[7]

It also publishes reports and training materials on how to introduce PPPs and as is evident from its goals, its primary aim is to promoted the development of markets through increased private participation and PPPs (World Bank, 2017). The world bank supports public-private partnerships in 76 countries with the underlying rationale that PPPs can help improve service delivery and the provision of basic infrastructure, including for the poor (World Bank, 2005).

The World Bank in a 2002 report prepared specifically for India and titled *Better Health Systems for India’s Poor*, recommended that in order to deliver improved healthcare services and achieve better health outcomes across all regions and for all socioeconomic groups, the country needed to promote its private sector and take advantage of its capacity (World Bank, 2002). Since the public system has largely been inefficient in successfully meeting people’s healthcare needs, it would therefore be wise to marketize the healthcare sector (Ibid).

Perusal of the policy papers of such institutions, especially the World Bank corroborates this claim. In a discussion paper brought out by the Health, Nutrition, and Population (HNP) group of the World Bank’s Human Development Network, four key policy recommendations were made:

- Governments of low- and middle-income countries should strengthen their Public-Private Partnership capacity
- These countries should Contract-out their primary level health facilities

[7] Quoted from the PPIAF website available at https://ppiaf.org/about-us

- Devise a Strategy to improving the performance of informal health providers
- Promote a sustainable and affordable health insurance model (World Bank, 2017).

The WDR of 2002 is clearly seen to be setting the stage for PPPs, extolling their potential for increasing accessibility and accountability of development services. It argued that aid agencies chose to work in countries through the PPP route as there is lack of trust and accountability in dealing with governments. A 2006 discussion paper by the bank also prescribed the PPP route as the alternative for governments facing fiscal constraints to make their healthcare delivery more efficient, to help address cost and investment challenges and enhance the quality of their health services (Nikolic & Maikisch, 2006) . Another report by the world bank on financing investment for the 2013 G20 summit (with inputs from the IMF, OECD, UNCTAD) emphasised the importance of PPPs and the need to support them with public guarantees and subsidies (IFC, 2013). A green paper on PPPs by the EU came out in 2004 recognized that during the previous decade, the PPP phenomenon had developed in many fields falling within the scope of the public sector. The desire to benefit more in public life from the know-how and working methods of the private sector and the need for private funding were the most important drivers for this change (EU 2004). The report also warned against the proclivity to become over-enthusiastic about PPPs, saying that they cannot be presented as a miracle solution for a public sector facing budget constraints.

3.5.2 How have Consultancies advanced the PPP case:

The transformation of the public sector in the last few decades has been significantly influenced by Management consultants. Governments across the world hire these consultants as experts in introducing cost-reducing and more efficient management practices in state owned enterprises (Pollit & Bouckaert, 2003). They have been instrumental in generating and disseminating literature supporting the tenets of a market led economy. Their influence on public policy can be gauged from the fact that they have been describe by policy analysts as the ‘shadow government in the US’ (Daniel & Barry, 2016). The free-market project in healthcare had been accompanied by a growing influence of multinational management consulting firms. International management consulting firms are an important part of the 'policy community' that is constantly working to promote back-door marketization of the health system. Despite having little or no experience in dealing with health systems and health policy

concerns and having conflict of interest issues[8], these consultants have continued to play a decisive role in health planning.

Consultancy businesses play an important role in public–private collaborations. They become an important liaison between governments, private healthcare providers, multinational and bilateral agencies. Through regular engagements, consulting firms and the private sector earn credibility as well as the respect and adoration of civil officials. These platforms allow the private sector to have a say in policies and practises that affect public health. Constant connection between the business, governments, and global institutions contributes towards legitimising conflicts of interest. Management consultants have been identified as essential levers in the public sector's process of altering management practises (Saint-Martin, 1998). The use of consultancy services increased significantly during the 1980s in the high-income countries and consultants have continued to remain extremely powerful in the subsequent decades. Their influence on the opening up of the UK's National health Service was so significant that it was labelled as 'Consultocracy' by some authors (Hood & Jackson, 1991). Overall, there is very little literature on the role of management consultants in the public sector, but what there is underlines the power that they hold and the influence they exercise.

PwC has been one of the first management consultants to endorse the PPP model. In a 2005 report titled 'Delivering the PPP Promise' they argued that PPPs are goal oriented as they have clear objectives unlike the SOE; they also offer more value for money for resource constrained governments (Howcroft, 2005). The report was also presented at the United Nations Economic Commission for Europe. It argued that PPPs can maximize the skillset of the private sector (Ibid). Mckinsey & Company in one of their working documents on PPPs presented a more balanced perspective arguing that PPPs have the potential to "play a critical role in tackling difficult challenges in areas such as public health and economic development that have proved resistant to government-only, business-only, and non-profit-only solutions…an optimal mix of the unique strengths of these different sectors can often accomplish much more than even the most determined effort by any one or two operating alone" (McKinsey & Company, 2009, p. 2). PwC in collaboration with Institute of Global health Sciences have also come out with a series of four reports that made the case for increasing role and growing benefits of PPPs in healthcare in various countries (PWC; UCSF, 2018). The reports argue that PPPs give governments other means of funding, developing infrastructure, and delivering services, while

[8] their clientele also includes private hospitals, healthcare providers and pharmaceutical companies.

the private partner assumes substantial financial, technical, and operational risks and is held responsible for predetermined results. They almost make it sound as if the motive behind increased private participation in philanthropic. The concluding report of the series tries hard to downplay the business opportunity that PPPs bring for private players and heightens the risk involved in working with the healthcare sector. It says:

> "…for the private sector, PPPs provide an opportunity to gain access to new markets at a lower risk profile, while contributing to a public good. Although public healthcare markets typically come with lower potential returns on investment, they offer opportunities to increase volume and market share, and allow the private sector to diversify their investment and service delivery portfolio." (PWC; UCSF, 2018, p. 9)

Conveniently, it overlooks the fact that PPPs bring one of the most reliable and low risk and steady flow of business for private companies. It's a captive market that the government opens for its private partner. A report by KPMG on the potential of PPPs in global health claims that the cost of achieving Universal healthcare is so exorbitant that it is a "bottomless pit" and PPPs offer a way to contain that (KPMG, 2018). It argues that although healthcare was not one of the first sectors to espouse the PPP route, it will become a cornerstone of 'health for all' strategies in many major markets in 15 years (Ibid).

Management consultants have been partnering with industry representatives in India like the Organisation of Pharmaceutical Producers of India (OPPI), All India Management Association (AIMA) and the Confederation of Indian Industries (CII). Collaboration with these influential lobbies provide them with a vantage point to propagate the idea of further commercialization of healthcare in India. An idea that these industrial lobbies would be too eager to not accept whole heartedly. Deloitte, KPMG and PwC; three of the big four of global management consultants have all published many reports advocating for the increased role of private partners in delivering of healthcare in India. In a report that PwC brought out in collaboration with the CII in 2014; it exhorts that PPP in healthcare in India has to potential to strengthen its health system. It claims that

> "PPPs in healthcare are challenging the notion that private healthcare is meant to be accessed by the affluent while public healthcare is meant for the poor. Rather than creating or exacerbating inequalities in healthcare, PPPs can equalize healthcare for all sections of people." (PWC; CII, 2014, p. 5)

Nowhere in the entire report one bit of actual evidence is presented to back these tall and intuitively known to be incorrect claims. However, the lack of evidence behind all the claims of huge benefits that PPPs are supposed to being to healthcare is palpable across the cross section of repots. All these assumptions that highlight the strengths of the PPP model from the consultants do not actually provide any evidence on the impact of the existing PPPs or at on their least their ability to deliver on the promises in the future. The same arguments that were once used to put the private sector on a higher pedestal are now beginning to be used to stress that PPPs are better.

Market expansion in healthcare; from Privatization to Public-private partnership:

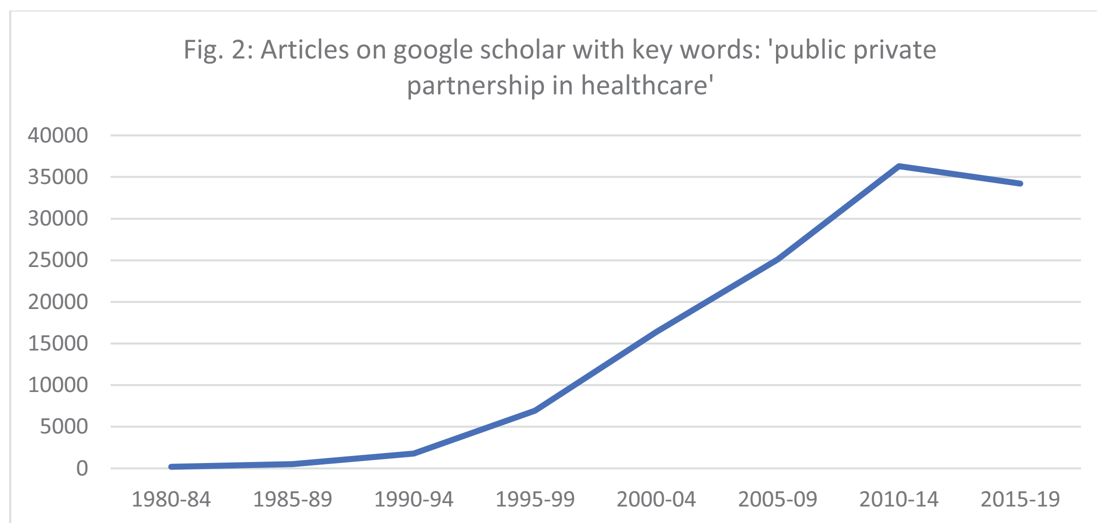
Private sector for long has been widely promoted by free-market advocates and neoliberal policy literature including NPM and the Washington consensus, as more efficient than the public sector. However, evidence-based studies have shown that efficiency is not a function of ownership, irrespective of public or private, rather it has been shown to depend on factors such as country context, the sector such as health, education, transport, water and so on and the nature of the market. A review of studies performed by the UNDP on the issue of public vs private efficacy in the healthcare sector reported that across high-, middle- and low-income countries there was no evidence to suggest that one form of ownership was more efficient than the other (UNDP, 2015). However, it did find that private for-profit hospitals were less efficient than private not-for-profit and government hospitals. Although it may seem counterintuitive but studies suggest that private hospitals incentivize over-diagnosis and over-treatment, thereby, significantly increasing cost of treatment and hence inversely affecting efficiency (Ibid). Roger Wetenhall has captured the ideological as well the semantic shift in development literature from privatization to public-private partnerships:

> "The term partnership is now a dominant slogan in the rhetoric of public sector reform, arguably capturing that status from privatization which held similar dominance through the 1980s and 1990s. As privatization captured the minds of so many would-be reformers over those decades and produced its own huge literature, so, it would seem, partnership especially in the form of public-private partnership is about to do the same" (Wettenhall, 2003, p. 77)

The promise of privatization has remained unfulfilled and private corporations have been increasingly associated with business malpractices, environmental degradation and lack of social responsibility. This has led to a widespread cynical public opinion against privatization.

An annual public opinion survey carried out in 18 Latin American countries reported on the dissatisfaction of privatization from 1995 to 2005. Popularly known as the 'Latinobarómetro poll'[9] the survey asked people in these countries whether privatization had been beneficial for their countries; As early as 1998, 40% of the people reported to have negative opinions about privatization, at the end of 2005 more than 60% of respondents in all reporting countries expressed that privatization was not beneficial for their country. A study from China reported that although workers were deterred by government's eagerness to supress spreading of discontent, there was an anger against private ownership of factories in the workforce (Cheng, 2006). It was getting clear that privatization would lose the war of popular perception for neoliberalism; private corporations were being associated with unethical business practices, tax evasions, environmental damage, human rights violations and redistribution was wealth looked like an impossibility.

The push for full-scale privatisation of healthcare was off the global agenda by the early 2000s, public–private partnerships became the new tool in the free-market ideology allowing them to expand into new markets, and connect with new consumers throughout the world. A simple literature search on google scholar on 'public-private partnerships in healthcare' corroborates the argument that there is a sudden rise in the PPP narrative in academic literature towards the beginning of the 2000s.



Source: Google Scholar

The anti-privatization sentiment found its strongest vindication after the 2008 financial crisis. Investment banks, the epitome of neoliberal ideology was found floundering causing the

[9] https://www.latinobarometro.org/docs/The_Latinobar%C3%B3metro_poll_The_Economist.pdf

biggest real estate crisis in the history of the western world. The World Bank has literally started reusing the 'trickle-down' moniker for PPPs instead of privatization now. In a 2015 report it argues that;

> "The underlying rationale for PPP interventions is that PPPs can help improve infrastructure, spurring economic growth that eventually reaches the poor ('trickle down' effect)". (World Bank, 2015, p. 8).

As the world bank explains on its webpage;

> "The financial crisis of 2008 onwards brought about renewed interest in PPP in both developed and developing countries. Facing constraints on public resources and fiscal space, while recognizing the importance of investment in infrastructure to help their economies grow, governments are increasingly turning to the private sector as an alternative additional source of funding to meet the funding gap." (World Bank, n.d.)

Privatization could prove to be a threat to the neoliberal agenda of expansion of market, therefore around this time there is a subtle shift in narrative and the language of international finance institutions, neoliberal think tanks and academicians and management consultants; public-private partnerships become the preferred strategy for market development instead of privatization. Even some of the staunchest advocates of Privatization have admitted that the term "privatization" tends to generate a lot of opposition and that terms such as "alternative delivery systems" and now "public–private partnerships" are more tolerable; they invite more people and organizations to join the privatization discourse and enable private organizations to get a market share of public service provision (Savas, 2000).

Scholars have also argued that the inefficiency and managerial failure of state-owned enterprises in developing countries that was often used as a pretext for their privatization, was a case of deliberate mismanagement to make public and political opinion more amiable to privatization (Petrecolla, et al., 1993). They argue that PPPs, sometime act as a proxy for direct privatization as a means towards market expansion (Ibid). Faranak Miraftab, a professor at the University of Illinois and a consultant at the community development program of the United Nations have called PPPs 'trojan horses' of neoliberal development (Miraftab, 2004).

The Indian Context

Partnership with the private sector has been a feature of India public health strategy for several decades now. However, the nature and constitution of these partnerships have undergone through a process of realignment, redefining the role of the market and the state in the delivery of healthcare (Baru & Nundy, 2008). Collaboration with non-state actors in the health sector was mainly restricted to NGOs and charitable organization in India until the 1980s. The role these organization played pivoted around family planning, community mobilization and health education. Health service provisioning was limited to TB care initially and subsequently in anti-malaria and small pox programs. Voluntary organizations and NGOs were provided financial support by the Indian government in lieu of utilizing their reach at the grassroot level. Government of India provided funds for the formation of the Central Social Welfare Board in 1953, the organization was responsible to provide grant in aid to NGOs.

However, the history of partnerships in the health sector with the philanthropic organizations in India goes back to the early 20th century. The Rockefeller Foundation established in 1913 in the USA was funding health programs even in pre-independence India. Some of the earliest interventions initiated by British India in partnership with the foundation were to prevent and control the spread of infections in British settlements in the Madras Presidency (Kavadi, 1999). The All India Institute of Hygiene and Public Health was established in 1932 with funds from the Rockefeller Foundation to fulfil the requirement of medical personnel and health workers necessary to implement the foundation's programs in the country (Ibid). In the decade after independence, the Rockefeller Foundation greatly expanded the range of its activities in India (Gordon, 1997). National Tuberculosis Control Programme (NTP) was formulated in 1962 by the government of India in partnership with the Rockefeller Foundation, UNICEF and the WHO (Duggal 2001).

In the post-independence years in India, it was not only Rockefeller Foundation that was expanding its activities but the newly formed Ford Foundation, which was the largest private American foundation at the time, also began to support the Indian government (Gordon, 1997). The National Family Planning Program was the first national health program launched in independent India in 1952. The Ford Foundation had an important role to play in the inception of the program through one of its beneficiary institutions in India called the Family Planning Association of India (FPA). However, in a few years after the launch of the program, the Ford Foundation began to play a more active role in its implementation, providing funds that

matched Indian government's own allocation towards the program, developing designs for program organizations and leading the training and knowledge dissemination aspects of the program (Harkavy, et al., 1968). However, the funding from the Ford Foundation was conditional to fulfilment of specificized criteria; one of the most crucial was the need to implement a National Population Control Program (Sarcar, 2021). In the later years, the program partnered with private nursing homes and medical specialists who could offer sterilization services in order to meet the program targets (Baru & Nundy, 2017). The National Malaria Control Programme (NMCP) was also started in partnership with the Technical Cooperation Mission of the USA and the WHO in 1953 (Duggal, 2001). Not-for-profit organizations referred to as 'Voluntary organizations' in the planning documents became key partners to the government in area of public health. In addition to the programs mentioned above, government began to partner these organizations across several health programs, including the National Immunization program. The Revised National Tuberculosis Control Programme (RNTCP) and the Reproductive and Child Health Services encouraged the forging of a number of PPPs including those with the for-profit private sector.

After the 1980s, PPPs were introduced into several other disease control programs and RCH program but also their design and operative guidelines underwent a change under the influence of external funding by the international funding institutions and their conditionalities (Baru & Nundy, 2008)(Larbi, 1999).

3.6 PPPs in the health policy and planning landscape in India

India didn't have a National Health Policy until 1983. Prior to that health planning and policy was done with the help of five-year plans. Baru and Nundy have done a chronological analysis of the nature of public-private engagements that the Indian government has had with the private health sector through various five years plans (Baru & Nundy, 2008). During the First Five Year Plan (1951-56), GOI entered into a partnership with the WHO and the UNICEF to implement the BCG immunization program. It was also proposed that the setting up of voluntary organizations would be assisted by the government to help in the TB control program (Ibid). A Central Social Welfare Board was set up to provide grant in aid to NGOs by the GOI (Duggal, 2001). During the Second (1956-61) and the Third Plan (1961-66), a large number of such organizations were also involved in the leprosy program and the provisioning of Maternity and child welfare services. Family planning program witnesses increased participation of NGOs; family planning clinics run by NGOs on government aid started providing sterilization

services (Baru & Nundy, 2008). During the Fourth Plan (1969-74), the non-government sector was envisaged as a development partner rather than a group of charitable institutions (Duggal, 2001). Income Tax incentives were given to private companies for investing in social development sector. Budgetary allocations were made towards NGOs for the first time during the Fifth Plan (1974-79) (Dubochet, 2011). Also, it was during this plan that for the first time, PHCs were given to NGOs to run on a PPP mode (Ibid). The Sixth Five Year Plan (1980-1985) was a major milestone in terms of the role of non-state actors in healthcare in India. Representatives of the sector became members of Planning Commission and various other advisory bodies. It was then that the idea of PPPs as seen now was implemented in the national health programs supported by the NPM approach (Baru & Nundy, 2008). In the Ninth Five Year Plan (1997-2002), the Mother NGO (MNGO) scheme was introduced under the Reproductive and Child Health (RCH) program by the Department of Family Welfare. This was a significant milestone in the role of non-profit sector in provisioning of health services in the country. During the Tenth Five Year Plan (2002-07), decentralization remained an overarching focus and NGOs had a major role to increase community participation. Planning commission became the nodal agency for the government-voluntary sector interface. NGOs with adequate expertise and experience had a greater role to play in RCH service delivery under the public-private partnership model.

Encouragement of private hospitals at the analytica and tertiary levels was initiated during the Eighth and Ninth Five-year Plans (Baru & Nundy, 2008). Contracting in and out of clinical and non-clinical services began during the Tenth Five Year Plan (2002-07) (Ibid). NGOs with adequate expertise and experience were allowed to participate in RCH service delivery under the public-private partnership model and were categorized as Mother NGOs and Field NGOs. Planning commission becomes the nodal agency for the government-voluntary sector interface (Planning Commission, 2002). During the Eleventh and Twelfth Five Year Plans (2012-17), both Non-profit and for-profit organizations provided a range of services under the public-private partnership framework. Plan document envisions a role for them in good governance, transparency, and accountability in the delivery of health services (Ibid).

National Health Policy 1983, committed itself to providing "universal, comprehensive, primary healthcare services, relevant to actual needs and priorities of the community at a cost that people can afford" (MoHFW, 1983, p. 3). It did not recommend the use of the partnership model in the current form that is known today but it did recommend the use of volunteers and

community participation in creating a decentralized model of healthcare "adequately utilizing the services rendered by the private voluntary organizations in the health sector" (Ibid, p.4). However, the goal was to create a system that was sensitive enough to the needs of the community in real time and was not a top-down system. The 1983 Health Policy did recommend expanding healthcare through the private sector. According to the National Health Policy of 2002, the private sector contributes significantly to secondary and tertiary care, but there is a perception that the quality of the private sector is not uniform and in some cases below standard, necessitating the formation of a regulatory mechanism to ensure the maintenance of adequate medical standards by institutions, as well as during the performing of clinical practice and delivery of medical care (MoHFW, 2002). The health policy acknowledges that there are huge gaps in the public health infrastructure, which has pulled people away from these facilities and towards private healthcare facilities. It also 'welcomed' increased participation of the private sector in primary, secondary as well as tertiary care services, provided regulatory criteria regarding 'minimum infrastructure and quality standards' are met (MoHFW, 2002, p. 30). It also recognized the contribution of both for profit and not-for-profit private sector in public health and advocates for a significantly bigger roles for NGOs and civil society institutions in the public health policy landscape of the country. NHP-2002 envisaged the "co-option of the non-governmental practitioners in the national disease control programmes so as to ensure that standard treatment protocols are followed in their day-to-day practice" (MoHFW, 2002, p. 31). It also recommended that a minimum of 10% of program budgets should be spent through NGOs and states were also 'encouraged' to 'hand over' an unspecified percentage of public health facilities to NGOs and civil society institutions. It also encouraged the creation of private insurance instruments to expand the extent of secondary and tertiary sector coverage under private health insurance schemes (Ibid).

The NPM language in support of PPPs in healthcare appear very prominently in a report by the PPP Sub-group of the erstwhile Planning Commission that was published in 2004. It argued that PPP would bring better quality of service and increased professionalism as they would have a clear customer focus (Planning Commission, 2004). Other benefits of PPPs enumerated by the report included cost effectiveness, higher productivity, accelerated delivery and recovery of user charges[10]. It also recommended that private sector should be 'comforted' enough that the risks of entering into a partnership would be shared (Planning Commission, 2004, p. 74).

[10] Introduction of user charges in public health facilities was recommended for the first time by the world bank in a 1987 report titled 'Financing Healthcare in developing Countries'.

Mirroring the NPM logic, it accused bureaucracy of being lethargic, corrupt and high-handed that can only be remedied by the positive forces of private competition (Ibid). A National Planning Workshop on PPPs in the Health Sector in India was subsequently organized at the National Institute of Health and Family Welfare (NIHFW) in 2005.

The National Commission on Macroeconomics in Health, a high-level group co-chaired by the finance and the health ministers of India having members that included the DGHS, prominent scientists and representatives from the world bank and the WHO presented its report in 2005. Although eponymously, the main focus was on the macroeconomic issues concerning the health system in India, the report also intended that the "commission would look into the issue of improving the efficiency of the delivery system and *encouraging public-private partnerships in providing comprehensive health care*." This report rued the limited government engagement with the for-profit private healthcare sector as it has not been as successful as with the not-for-profit sector. It highlighted three emerging forms of PPPs to increase the engagement of the for-profit private sector with the public sector, namely; handing over of public facilities to the private sector for management in the nature of a joint partnership, contracting the for-profit sector for medical treatment and contracting of support or ancillary services.

National Health Policy of 2002 departed from the fundamental concept of the NHP 1983, which had committed itself to the vision of the Alma-Ata Declaration through ensuring universal provision of comprehensive primary health care services. However, the impact of health sector reforms and SAP is palpable throughout the entire NHP'02 document. It recommends increasing the contribution of the private sector in providing health service for the population group which can afford to pay for services and welcomes the participation of the private sector in all areas of health activities primary, secondary and tertiary health care services. Medical tourism was also recommended to be promoted as one of the priority areas by the health policy. Many of the recommendations in the 2002 health policy reflects influence of another report; a report by an Advisory Council on Trade and Industry headed by Mukesh Ambani and K. M. Birla appointed by the then BJP government led by Mr. Atal Bihari Vajpayee. The council recommended that through tax exemptions and incentives, the private sector should be encouraged to participate in the secondary and tertiary sectors, depending on their financial capacity, various population segments should contribute to the cost of healthcare. (Vijay, 2007).

National Health Policy 2017 further depended government's commitment to the PPP model recommending the use of PPP across all levels of care. It recommended the increased use of partnerships with for-profit as well as not-for-profit healthcare providers to close the gap in the availability of tertiary level care in India, especially in rural areas. A mechanism of 'empaneling' select tertiary care hospitals from the private sector is recommended so that the government can purchase these services as and when they are needed. At the primary level, it avows collaboration with the private sector for operationalizing health and wellness centers. Partnerships are recommended across services including "diagnostics services, ambulance services, safe blood services, rehabilitative services, palliative services, mental healthcare, telemedicine services, managing of rare and orphan diseases." (MoHFW, 2017, p. 21). It also envisions greater role of PPPs in urban healthcare delivery "given the large presence of private sector in urban areas." (Ibid, p.10).

There seems to be an incongruity or a shift in government's position related to PPPs in the 2017 health policy compared to the eleventh Plan. The Task force under the plan recommended PPPs only for primary healthcare services, however, the national health policy 2017 takes a polar opposite position stating that:

> "…free primary care provision by the public sector, supplemented by strategic purchase of secondary care hospitalization and tertiary care services from both public and from non-government sector to fill critical gaps would be the main strategy of assuring healthcare services." (Ibid, p.8)

The 15th Finance Commission that submitted its report in 2021. A High-Level Group on Health Sector under the chairmanship of Dr. Randeep Guleria, Director, AIIMS, along with members including NITI Aayog member Dr V.K. Paul, Dr. Devi Shetty, Chairman of Narayana Health City, Bengaluru, Dr. Naresh Trehan of Medanta Medicity, Gurugram and Prof. K. Srinath Reddy, President of the Public Health Foundation of India, made some rather bold recommendations in favor of PPPs in Healthcare arguing that private practitioners should be allowed to practice in District Hospitals:

> "In public health facilities, it is very important that spare infrastructure and facilities be fully utilized, towards this objective a panel of specialists from the private sector may be drawn up for all district hospitals and may be permitted to treat patients and

> undertake procedures, without crowding out the patients seeking direct treatment at such hospitals." (Finance Commission of India, 2019, p. 39)

Evidently, ever since independence, Indian health policy and planning has considered the private sector; both for-profit as well as not-for-profit as their important partner. The five-year plans, special reports as well health policy documents are a testament to that. However, one program that arguably gave the strongest impetus to PPPs in the health sector in India was the National Rural Health Mission launched in 2005.

3.7 NRHM- A milestone in the growth of PPPs in healthcare

NRHM launched in 2005 provided a major impetus to the partnership model in healthcare in India. While the Mission covers the entire country, it has identified 18 States for special attention. These states are the ones with weak public health indicators and/or weak health infrastructure. These are Arunachal Pradesh, Assam, **Bihar**, Chhattisgarh, Himachal Pradesh, Jharkhand, Jammu & Kashmir, Manipur, Mizoram, Meghalaya, Madhya Pradesh, Nagaland, Orissa, Rajasthan, Sikkim, Tripura, Uttaranchal and Uttar Pradesh. These states termed as the Special/High Focus States were to have one Accredited Social Health (ASHA) worker in every village with a population of one thousand. The Mission's was launched with the aim "to provide accessible, affordable and quality health care to the rural population, especially the vulnerable sections" (MoHFW, 2005, p. 5). It also aspired to reduce the Maternal Mortality Ratio (MMR), Infant Mortality Ratio (IMR) and Total Fertility Rate (TFR) in the country within a seven-year period. The Mission also envisioned to raise public spending on health from 0.9% to 2-3% of GDP; however, as it is evident the spending it yet to increase. Pre-NRHM, transfer of funds from the GOI to the state governments used to be done on a programmatic basis by the Departments of Health and Family Welfare and Department of AYUSH; NRHM brought all such heads within its own purview. From the eleventh plan onwards, a single budget head was introduced for the activities under the Mission. A minimum amount was earmarked for various disease control programs, above which the states could direct funds towards other priority areas. It was proposed in the implementation framework that 5% of the total NRHM outlay should be allocated towards PPPs with voluntary organizations (MoHFW, 2005, p. 9). PPPs benefitted from this funding arrangement as states, particularly those who did not have a robust public health system, directed larger share of funds towards them. Promoting public-private partnerships for achieving public health goals was one of the key implementation strategies of the mission (MoHFW, 2005). A strong impetus to the

PPP approach in the health sector was provided by the NRHM in India. It formalized the promotion of PPPs for achieving public health goals as a national strategy. The PPPs were identified as a potential solution to improve inadequate healthcare delivery and NRHM supported them as a tool to increase administrative efficiency and support public health goals (NITI Ayog, 2019). One of the three task groups set up initially by the NRHM was on public-private partnerships. It envisaged a larger role for the for-profit private health sector in financing and provisioning of health services:

> "Public and corporate sectors can play innovative roles in financing and providing healthcare services. Active engagement by corporates, both philanthropically and through the core business and Corporate Social Responsibility (CSR) initiatives, is to be explored…" (MoHFW, 2013, pp. 53,58).

The task force was reconstituted as the members couldn't reach a consensus on the draft released by the earlier task force. Strengthening of the public sector health system and expanding the pool of health professionals for public health goals were two keys issues that were taken up by the new task force for consideration.

> "The Group felt that there was a need for partnerships with the non-governmental sector but these need to be defined very clearly as there was an equally important need to strengthen the public system. In a way, the group saw partnerships as a way of strengthening the public system as also a means to widen the range of professionals available for meeting public health challenges" (MoHFW, 2006, p. 4)

The Task Group on PPP also recommended that Partnerships with clinical professionals outside the public system are needed to improve the quality of healthcare being provided in the public healthcare system, alluding to the commonly held belief that service quality in the private sector in better than that provided by the public sector (Ibid). However, neither the NRHM implementation framework nor the Task Group dealt with the issues that prevailed in the private health sector in India as a result of decades of non-regulation (Shukla, 2005). Issues like the lack of standardization of quality of health services, standard treatment protocols, cost of treatment etc. between government and non-government services providers was acknowledged by the Mission. It also remarked that "a legal framework to ensure minimum standards of all Government and Non-government health care facilities is necessary" to have a more ethical and transparent partnership and that the "NRHM will provide a platform for

improved regulation, setting up standards, dissemination of standard treatment protocols, franchising for seeking standard rates and costs for agreed services, etc." (MoHFW, 2005, p. 84). However, over the years these commitments were neither addressed nor fulfilled.

Even though PPPs were an important part of India's public health strategy ever since independence; the NRHM led to it institutionalization in the health system. Several of the national health programs that came under the NRHM umbrella had in-built mechanisms for incorporating partnerships in the implementation of those programs. The Reproductive and Child Health (RCH) II and the National Tuberculosis Control Program (NTCP); two of the largest health programs under the NRHM had the largest number of PPPs within themselves. Several franchising, social marketing and contracting models constituted the RCH program covering services that range from managing hospital facilities by leading NGOs, service delivery, which included family planning services, MTP, treatment of STI/RTI etc and also hiring of healthcare workers. Other than various national health programs that were already using the partnership model, the second phase of the Reproductive and Child Health (RCH) program significantly strengthened the role of the non-state actors in healthcare in India.

RNTCP partnered with private doctors as well as clinics in order to help increase the detection rate of TB cases. Private sector involvement in TB is seen as important for continuity in care; low costs of treatment under RNTCP; and monitoring of patients in order to control TB (Sandhu, 2011). Mobile Medical Units (MMU) were an important initiative under the NRHM to provide a range of health care services for populations living in remote, inaccessible, un-served and underserved areas (MoHFW, 2005). These mobile units were operationalized with the help of either the Rogi Kalyan Samiti (RKS) or private contractors including NGOs and were to be attached to the district hospital /CHC. The Immunization and Polio Eradication Programmes also used the partnership route with local partners as well as international partners like the WHO, UNICEF and the Rotary International. Under the Janani Suraksha Yojana (JSY), private health facilities were accredited under the program and were allowed to offer delivery and post-delivery care to women for promotion of institutional delivery.

One of the most palpable impacts of the NRHM was the increase in the role of NGOs in providing health services. NGOS were already an important partner in various national health programs being run by the government but the kind of impetus they got from NRHM was unprecedented. Scholars have described this large-scale involvement of NGOs by the program

as the NGOization of government in delivery of health services (Bajpai & Saraya, 2013). Signifying the role of the non-government sector, the framework of implementation for NRHM stated:

> "Besides advocacy, NGOs would be involved in building capacity at all levels, monitoring and evaluation of the health sector, delivery of health services…The effort will be to support/facilitate action by NGO networks in the country which would contribute to the sustainability of innovations and people's participation in the NRHM" (MoHFW, 2005, p. 41).

The Mother NGO (MNGO) scheme was introduced under the RCH program in NRHM; MNGOs were bigger NGOs which were given a dual role of implementation as well supervisory of smaller Field NGOs (FNGO) for the provisioning of services like Family Planning, Mother & Child Health, Immunization and access to institutional delivery. The scheme gave grants to big NGOs called Mother NGOs (MNGOs) in allocated districts, who in turn issued grants to small NGOs called Field NGOs (FNGOs). Each Mother NGO was expected to work with only 3-4 Field NGOs (FNGOs) from each district; and could work in only 1-2 districts to keep them focussed on the districts that they work in. The second phase of Reproductive and Child Health Program (RCH II) was launched in the year 2005 under NRHM. RCH II introduced the concept of Service NGO (SNGO). Service NGOs are expected to provide a range of clinical and non-clinical services directly to the community as an integrated package of RCH-II services. Some of the services expected to be provided by Service NGOs include safe deliveries, neo natal care, treatment of diarrhoea and ARI, abortion and IUD services, RTI/STI etc (Ibid).

NRHM provided an opportunity for the state and the market to increase private participation in healthcare (PHRN and JSA, 2017). The NRHM model was based on strengthening the NGO framework and presenting them as a benchmark of service quality and ethical practice to the for-profit private sector.

> "The NRHM recognizes that within the non-governmental service there is a large commercial private sector and a much smaller but significant not for profit sector. The not-for-profit centres which are identified as setting an example of pro-poor, dedicated community service would be encouraged used as role model, benchmark, site of community centered research and training to strengthen the public health system and

> improve the regulatory frameworks for the non-governmental sector as a whole" (sic). (MoHFW, 2006, p. 9)

Seven years after the launch the RCH II program, the NRHM launched RMNCH+A (Reproductive, Maternal, New-born, Child and Adolescent) Health strategy. The argument was that the inter-linkages between various programme components that targeted diverse demographics were getting lost. Therefore, a cohesive was needed to achieve the health goals by establishing a 'continuum of care' that would include integrated service delivery at various life stages including, pre-pregnancy, childbirth, postnatal period, childhood, adolescence and through reproductive age. Reducing maternal deaths by bring down the number of unintended pregnancies was one of the key goals of the program, naturally family planning services were a priority. Focus of health planning was shifted from district level to block and community level and partnerships were one of the key strategies to increase community involvement. Policies on drugs, diagnostics, equipment, procurement system and logistics management, Comprehensive abortion care and Behaviour changing communication all recommended use of public-private partnerships in the strategy document.

> "In order to reach underserved/un-served areas in order to supplement public health care delivery, RMNCH+A services can be brought in and contracted out to accredited private providers, organisations and NGOs. Also, in future there will be focus on social franchising and accreditation of private providers to provide RMNCH+A services" (MoHFW, 2013, pp. 53,58).

Although the NRHM advocated for partnership primarily with the not-for-profit organizations and accepted that a well-funded, well-functioning, effective and efficient public sector in health care at all levels-from the village, the sub centre, the PHC, the CHC to the district level was essential to achieve the public health goals in India; it spawned a process of further withdrawal of the state in ensuring public health. The idea that desired public health outcomes can be achieved even with restricted participation of the state got entrenched. In a way the NRHM provided an opportunity for the state and the market to arrive at an agreement to involve private sector partners; both for-profit and not-for-profit and raise their status as stakeholders in the delivery of healthcare (PHRN and JSA, 2017).

3.8 NITI Aayog's push for PPPs

NITI Aayog was constituted in 2015 to replaces the erstwhile planning commission as government's apex think tank and its vanguard in formulating public policy. From the time of its inception, through various report it has been advocating the increased participation of market forces in previously state led social sectors. Its reports are often replete with the NPM rhetoric of 'public sector is inefficient' and 'markets are good'. In its report titled 'Strategies for new India' it states that the delivery of public goods and services is rendered inefficient by 'red-tape' and '**burdensome over-regulation**' of private investment (NITI Aayog, 2018). In December 2019 it brought out a draft proposal with plans to run select district hospitals. These district hospitals should have a minimum of 750 beds and approximately half of them is to be labelled as "markets beds" for which the contactor termed as 'the concessionaire' in the draft proposal, would be entitled to levy appropriate charges (NITI Aayog, 2019). District hospitals are an integral part of the public health system in India and the only option to avail tertiary care for a large section of the rural population. Outsourcing some of the largest and the well-performing hospitals to the private sector will not only weaken the public health system but it also has the potential to increase financial burden of healthcare on people. This move will also provide the private partners with a captive 'customer base'. In the spirit of the equal sharing of both risks and rewards of entering into a partnership, this model seems to be heavily skewed towards benefitting the private partner at minimal risk. In a meeting with stakeholders, it unveiled its plan to also allow these private contractors to set up medical colleges that would be attached to these district hospitals. A similar proposal was also floated by NITI Aayog in 2017 to promote PPPs in treating NCDs at district hospitals. 'The Concessionaire' according to the draft agreement could bid for a 30-year lease over parts of a district hospital that is 'reasonably well-functioning and has a fair patient load' (NITI Aayog, 2017). It's interesting to note that in both these proposals, the pre-condition that the health facilities should be 'well-functioning' or big enough with a certain number of beds and patient foot-fall; is meant to benefit the private partner while all that the government will receive is the benefit of efficient private management and better quality of care. It stands contrary to one of the fundamental tenets of public-private partnership, which is, equal risk sharing by both partners.

A noticeable difference in the implementation of the public-private model in India now compared to earlier partnership initiatives from other countries is that previously PPPs were implemented in times of economic crisis. In order to reduce their budget deficits states needed to cut their funding in the health sector; PPPs gave them an alternative to share this financial

burden on the private partner. India, on the other hand, has experienced unprecedented economic growth post liberalization and hence the rationale of lack of funds as one of the determinants of introducing PPPs doesn't really fit in the Indian context (Das, 2007). The majority of PPPs today are issue-specific by design, focusing on restricted and targeted vertical interventions to combat infectious diseases, with little regard for the larger health system implications of their operation. With the establishment of disease silos, this has resulted in an increasing fragmentation of health financing.

3.9 Some popular forms of PPPs in India

Various models of public-private partnerships exist in India, some of the prevalent forms of PPPs are:

- Contracting
- Build-Operate-Transfer (BOT)
  - User-Fee Based BOT models
  - Annuity Based BOT models
- Build-Operate-Transfer (BOT)
  - Modified Design-Build (Turnkey) Partnerships
  - Design-Build-Operate (DBO)
- Social Marketing
- Franchising: Partial, Full and Branded clinics

Contracting Out- Agreement for either clinical or non-clinical services that are to be provided 'off-site'; away from the government health facility. These are generally used to provide service in rural and remote areas. Complete transfer of a health facility to be managed by a partner also comes under this category.

Contracting In is the outsourcing of specific services within the premises of a public facility. This model is generally used for high-end technological interventions for which the government lacks the expertise. It should be highlighted here recently some academics have questioned whether 'contracting' should be considered a form of PPP at all considering the fact that most of them are mere outsourcing of a particular service (Richter, 2004). They argue that it is a form of pure outsourcing where the parties involved don't have a shared objective or don't share risks and benefits proportionally (Wettenhall, 2003). However, contracting is one of the oldest formats of PPPs and in itself can represent a wide range of arrangements.

Venkatraman has described the co-location model as an important type of contracting-in PPP where highly specialized services are provided by a partner within the premises of a publicly owned health facility (Raman & Björkman, 2015). Contracting of public services that entails more overt attempts to mimic the market in the management and delivery of public services, particularly where outright privatisation, i.e., a change of ownership has not been feasible, is at the core of PPPs (Savas, 1999). Contracting is also one of the key features of the NPM tenets and is regarded as the most common market-type mechanism (Walsh, 1995). It is congruous with the larger NPM ideology of changing the role of state from a provider to a purchaser. As far as public-private partnerships are concerned, some authors have stated that it is the foundation of PPPs (Rajasulochana & Dash, n.d.). It is the most widely used forms of public-private partnerships. Although NPM literature rarely uses the specific term PPP; it is rife with advocacy for using Contracting in general and contracting out in particular as one of the key components of public sector reform.

Build-Operate-Transfer (BOT) Partnerships: Build–operate–transfer (BOT) is a form of partnership where a private entity receives a concession from the public sector to design, finance, build and operate a facility as agreed in the concession contract (World Bank, n.d.). The private partner is generally referred to as the 'concessionaire' and the concession received can be financial in the form of capital investment or tax incentives as well as non-financial, for instance giving free land to develop the specified project. The concessionaire is entitled to operate and profit from the revenue generated from the facility for the term of the agreement at the end of which the facility is expected to be transferred back to the government, unless the government wants to continue with the partnership and the concessionaire is willing as well. In the User fee-based BOT model, costs are recovered mainly through user charges by the private partner, whereas in the Annuity Based BOT model a separate channel of financial assistance is opened by the government for encouraging annuity-based PPP projects. A variant of this approach could be to make a larger upfront payment during the construction period (DEA, 2011).

Build-Operate-Transfer Model		
State Government	**Private Partner**	**Financing Mechanism**
Provides land for the project to reduce the	Responsible for building, financing, operating and	Private partner finances the entire project

initial capital investment	managing the facility for the partnership period	
Incentives in the form of tax/tariff concessions		Revenue generated during that period is utilized to recover the investment cost by the private partner until break-even point is reached and generate profit afterwards at mutually agreed rates
Ownership can be transferred at the end of the partnership period		Payment to the government is made in the form of annuity or indirectly in the form of rate concession to beneficiaries
		Sharing of a small portion of revenue is also allowed in some cases
These are typically long-term partnerships; tenure of these partnerships is generally for more than 30 years.		

Source: Adapted from (World Bank, 2014)

Co-location Model		
State Government	**Private Partner**	**Financing Mechanism**
Allows a private partner to set up a separate facility inside an existing government health facility	Invests in building, upgrading, expanding and/or equipping the facility	Revenue generation through user charges
Ownership remains with the government	Put in additional human resources to manage and operate the new facility	Pricing structure decided by both the partners. Some procedures or beds are under discounted price categories and the government reimburses the private partner for those
Government pays for the patients referred by the government facility	Private partner is free to operate the facility as an independent revenue generating facility.	Sharing of demand risk is central to the idea of this model.

Source: Adapted from (World Bank, 2014)

Modified Design-Build (Turnkey) Partnerships: These partnerships are generally implemented in infrastructural development PPPs where a basic infrastructure is already available but it needs repair or upgradation. It can also be used for completely new projects where intermediate milestones are set and the next phase is begun only when the previous is successfully completed by the private partner and renumerated by the government.

The Design-Build-Operate (DBO) model is implemented in the construction of a new hospital or other health facility, the ownership of the health facility lies with the public sector which also finances the construction of the new facility. The private partner builds and operates the facility for the agreed tenure of years (World Bank, n.d.).

Social Marketing: Partners use marketing techniques to achieve a social objective, which is mainly but not limited to behavior changing communications. Social marketing has been used to promote the use of contraceptives, oral rehydration solution, iron and folic acid tablets.

Social Franchising: This is primarily a business model in which a manufacturer or provider of a product or service (the franchiser) grants exclusive rights to a local independent agency (franchisees) to provide health care services in a particular area abiding by the processes sanctioned by the franchiser. The franchisees contribute resources to set up a clinic and pay membership fee to the franchiser (Bhat et al.).

3.9.1 The inadequacy of existing PPP models:

Several Scholars have flagged the lumping together of two very fundamentally different private players, i.e., for profit and not-for-profit as one of the elementary issues in defining PPPs (Saith & Mehrotra, 2009). State's engagement with these two representatives of private healthcare market in India has been long and it has undergone several transformations in its history of close to seven decades. As the compositions of these actors have changed over time, so has the nature of their partnerships with the government (Baru, 2009). However, models of PPPs have not evolved to absorb and represent this transformation. For instance, the rise of global foundations in public health in the last two decades has been nothing short of astronomical. They have come to dictate and drive the global health policy and shape the global landscapes collaborating with and many a times challenging UN agencies like the WHO and the UNICEF. Multilateral Banks have also increased their direct intervention in the health sector and along with global foundations they prefer private partners to implement their health programs or to award financial grants. This has given rise to arrangements where the state is in partnership

with the international funding agency as well as an implementing partner. Existing PPP models have failed to capture this development and have failed to either theorize the phenomena or develop comprehensive models for their analysis.

Conclusion: The inherent contradiction between the quest for profits by the private entity and the need to deliver social goals by the government is evident in the case of PPPs in healthcare. There is little to no evidence that they achieve better health outcomes compared to the public health system. Still, the optimism surrounding PPPs in the health sector continues to grow unabated. The optimism that appears to be spontaneous and organic on the surface is actually driven by the neoliberal agenda to limit the participation of the state in the health sector and encourage as well as increase the participation of market forces. However, rise in pro-PPP rhetoric in the health sector overlaps with the waning of pro-privatization narrative. Privatization has been the front runner of the neoliberal agenda until the late 2000s. As the global economic crisis of 2008-09 precipitated the decades of popular discontent against the massive liberalization of public assets and services, of which privatization was the face; the risk of carrying with the 'grammar of privatization' meant risking the liberalization agenda itself. Therefore, a systematic move in strategy is discernible among what Hayek had described as 'Second-hand purveyors' of ideas, from privatization to public-private partnerships. PPPs like its ideological progenitor believe that the issues in health are uncomplicated and simple that have sustained only because the state is inefficient. And solutions lie in the expertise that private sector brings. However, as any public health person would agree, these issues are anything but that. Rarely a PPP promotional document talks about the social, legal or justice dimensions of health. Taking from the ideological pedigree of neoliberalism, they treat health as a tradable commodity ignoring the fact that even in economic literature it is treated as a public good as it is subjected to a number of externalities. Indian health policy in terms of PPPs also lacks depth as well as width of understanding PPPs. Over the years, several policy documents have narrowly defined PPPs, shied away from discussing monitoring and oversight mechanisms and have failed to keep up with the changing landscape of the nature of 'for-profit' and 'not-for-profit' constituents in the markets as well as the entry of newer constituents like the international donors.

Chapter IV- Bihar- How have PPPs in healthcare grown at the sub-national level

Bihar was one of the earliest states to take up the public-private partnership routes propagated by the NRHM. It opened up formal channels for tapping the potential of the private healthcare sector more systematically and significantly than before (Gupta, 2009). Along with a large inflow of funds, the NRHM also brought huge pressure on the weaker states to spend the funds. Bihar was one of the EAG states and found it difficult to utilize the NRHM funds through its weak public health system alone. PPPs came to the state as a convenient option to utilize NRHM funds and also ensuring delivery of primary healthcare services (Gupta, 2009). RCH II was one of the biggest programs supported by the NRHM; during 2005-06 26.14% of the total NRHM outlays were demarcated for the RCH II program only. However, funds under the RCH flexipool could not be utilized for the construction of new health facilities and not more than 8% of the pool could be spent on salary. This practically forced states like Bihar that had huge shortage of healthcare facilities as well as health workforce. It could neither use the money to build infrastructure nor use it in strengthening its health human resources as much as it required, to engage with non-governmental partners to utilize the NRHM funds (Ibid). The explosion of PPPs in the health sector in Bihar post-NRHM can be gauged from the fact that some twenty-six new public-private partnerships were started in during 2005-08 (Gupta, 2009).

As important as NRHM and its espousal for public-private partnerships is in case of Bihar, it is not the only factor that led to the sudden spurt of PPPs in healthcare after 2005. Change in the political economy of the state led by a newly elected government introduced the beginning of neoliberal reforms in the state. It also brought the state in international aid organizations' focus; some of the international aid that the state received was in the form of credit that came with certain conditionalities. These conditionalities needed the state to implement NPM reforms in its governance and supporting the growth of private markets. However, the way neoliberal policies are disseminated and implemented at a micro level differs from the national and the global level. Social factors shaped by hundreds of years of production relations and ownership of wealth impact how present day social and economic structures have been formed. In case of Bihar change in the caste-class relationships and land ownership structure determined when and how the above-mentioned changes took place. A near complete upper caste control over the social, political and economic spheres in the state that remained for many decades

after independence and the challenge posed by the rise of OBCs during the 1980s have shaped the development of healthcare market in the state.

4.1 Bihar: An introduction of the state

Bihar is a state landlocked between Nepal in the north, Jharkhand in the south, Uttar Pradesh in the west and West Bengal in the east. It is the 12th largest state in the country in terms of geographical area and third most populous state. According to the last population census, the total population of Bihar was 104,099,452, nearly 90% of which live in rural areas and almost three fourth are dependent on agriculture for their livelihood.

Table 1: Key Demographic Indicators in Bihar

Demographic Indicators	Bihar	India
Total population (Census 2011)	10.4	1210.85
Male	5.42	623.27
Female	4.98	587.58
Sex ratio (female/male)	918	943
Population Density (per sq. KM)	1106	382
Urban Population %age	11.29	31.14
Literacy	61.8	74.04
Male Literacy	71.2	82.14
Female Literacy	51.5	65.46
Birth Rate	26.2	20
Death Rate	5.4	6.3
Total Fertility Rate#	3.4	2
Infant Mortality Rate#	48.1	35.2
Neonatal Mortality Rate#	36.7	24.9
Under Five Mortality Rate#	58.1	41.9
Maternal Mortality Ratio (SRS 2016-18)	149	113

Source: National Health Profile 2020 and # NFHS 5

The female/male ratio of the population is 918 against the national average of 943. It is the most densely populated state in the country (RGI, 2012). The state has the largest pool of young population in India and more than 60 percent population are below the age of 25. The literacy rate in the state is 61.8% and the female literacy rate (51.5%) is significantly lower than the male literacy rates (71.2%) in the state (Ibid). The literacy rate among Schedule castes (SC)

population was 48.6% (Ibid). The state is divided into nine divisions, 38 districts, 101 sub-divisions, 534 blocks and 45,102 revenue villages (GoB, 2018). 45.5% women in the 15-49 age group in rural Bihar are not literate, that's almost half of all rural women. It makes them more vulnerable to an early marriage and subsequently an early underage childbirth. Significantly increasing the risk towards their own health and life as well as of their new-borns. NFHS 5 data revealed that 41% of the women in Bihar are still getting married before the age of 18, pointing to a possibly significant correlation between literacy and marriage (IIPS, 2022). Considering that the figure recorded during NFHS 4 was 42.4%, it's only fair to say that the improvement has been utterly unsatisfactory to the detriment of thousands of young women (IIPS, 2017).

Table 2: Social Composition in Bihar, Census of India 1931		
Upper caste	Brahmin, Bhumihar, Rajput, Kayastha	13.7%
Backward Castes	Yadav, Kurmi, Koeri, Baniya	20.2%
Extremely Backward Castes	Kahar, Mallah, Teli, Tanti, Kanu, Lohar and others	18.2%
Scheduled Castes	Chamar, Dusadh, Mushar, Dhobi. Bhuiya, Dom and others	15.9%
Scheduled Tribes	Santhal, Munda, Oraon, Gond and others.	9.9%
Religious Minorities	Muslims, Christians, Sikhs, others	21.3%

Source: (Robin, 2009)

There has not been a cast census since the one conducted in 1931. However, NSSO 61st round did report that OBCs constitute 58.7% of the total population in the state (NSSO, 2007). Scheduled Caste population in the state was 16.9% and Scheduled Tribes were 0.6% of the total population (Ibid). Since most of the tribal areas in the erstwhile undivided Bihar went to Jharkhand in the bifurcation of the state in 2000, therefore the steep fall in the population of STs is observed. The 2011 census also enumerated the SC population in the state and found it to be 15.9% of the total population (RGI, 2012). However, even within the SC category, some caste groups are extremely marginalized compared to other within the category and have not benefitted much either form the land reforms or from the social justice movement in the state. To identify these extremely marginalized castes the GOB formed a Mahadalit Commission in 2007. The Commission has submitted two interim reports till date. In the first report, it recommended to include 18 castes as the extremely weaker castes amongst the list of Scheduled

Castes (Kumar & Somanathan, 2016). In the second recommendation, the commission proposed that two more castes should be moved from the list of Scheduled castes to the list of extremely weaker castes or Mahadalits. Recently the Commission has recommended 'Chamar' caste to be included in Mahadalit category as well after studying the different aspects of their social, educational, and economical condition in its 3rd recommendation[11]. This means that out of the 22 Scheduled Castes in the states, all except Dusadh caste, were considered extremely marginalized and categorized as Mahadalits in the state. This also insinuates how the social justice movement in Bihar failed to benefit the most neglected, marginalized and discriminated communities in the state. The movement credited with the stellar rise of the dominant OBC castes did not lead to similar consequences for the scheduled castes.

4.1.1 Economic Situation in Bihar:

Bihar has the lowest per capita income in the country; according to the Economic Survey of 2020-21 it was Rs. 50,555 (GOB, 2021). In terms of Wealth quintiles reported in the NFHS surveys, 52.9% percent of the surveyed households in Bihar were categorized within the lowest wealth quintile (IIPS, 2017). No other state had such a large chunk of its population in the bottom most wealth quintile as Bihar. Only 3.3 percent of the population belongs to highest wealth quintiles (Ibid).

Bihar is one of the least developed states in India. According to the multidimensional poverty index designed by the NITI Aayog, Bihar is the worst performing state in India (NITI Aayog, 2021). On almost every key development indicator including child health and nutrition, maternal health, education, financial income, access to housing and electricity, the state is one of the worst performing in the country (Ibid). To understand the dismal state of affairs in Bihar, one has to look at the social and political changes that have occurred in the state. Caste composition and the deprivations it has led to for a large section of people and the movements that have risen against the exploitation and deprivation have played a deciding the direction in which development politics in the state has gone. Concentration of agricultural land amongst the minority upper castes, the political, economic and social power that the agricultural surplus brought to them and failure to comprehensively implement the land reform legislations prevented the redistribution of resources in the state. It stopped the modernization of agricultural economy in the state making it one of the least productive agricultural economies in India (Bandyopadhyay, 2009). Economic factors like implementation of the Freight

[11] https://www.mahadalitmission.org/BMVM-Introduction.php

Equalization Policy led to the lack of industrialization of the state and the bifurcation of the state took away the mineral resources that were significant to the revenue of the state.

The late 1980s to the mid-1990s were the years when the neoliberalization of the India economy was decidedly set in motion. In order to overcome the economic distress that the country was facing in the 1980s, it adopted a set of neoliberal economic policies to revive and reform how its economy was organized. These policies implemented in the 1990s were not adopted by each Indian state uniformly. In case of Bihar its advent was delayed by almost a decade; until 2007, economic growth in Bihar was significantly lower than the national average and close to 80% of the state's expenses were met by central receipts (IBRD, 2010). During the tenth plan period (2002-07) annual GSDP growth rate was 5.6%; the relatively lower growth rate in large parts was attributed to the negative momentum from the previous years and the bifurcation of the state in 2000, which meant that almost entire mineral reserves and heavy industries went to the new state of Jharkhand (Kumar & Raj, 2013). Strong signs of growth started to become apparent in a few years as keeping the fiscal deficit was a consistent policy goal in the state. During the Eleventh Plan period (2007-12) annual GSDP growth rate burgeoned to 11.9%. Bihar has experienced high economic growth rate in the 2004-05 to 2014-15 decade (Table 3).

Table 3: Economic Growth rate in Bihar	
Financial Year	**GSDP growth**
2005-06 to 2014-15	10.5%
2015-16	7.5%
2016-17	10.3%
2017-18	11.3%
2018-19	10.5%
2019-20	10.5%[12]

Source: Assimilated from different Economic Survey Reports, Government of Bihar.

During this decade the Gross Sate Domestic Product (GSDP) was 10.1% (GoB, 2018). In fact, during the first half of the decade, the growth rate was 11% and the turnaround was celebrated as a success model by the Economist and the New York Times (Polgreen, 2010). In the fiscal year 2020-21, the annual GSDP growth rate of Bihar was the highest in the country, compared

[12] It is noteworthy that during the financial year 2019-2020 Bihar's GDP growth of 10.5% was higher than the national GDP growth.

to the India year on year GDP growth rate of 4% Bihar registered a growth rate of 10.5% (GOB, 2021).

The federal structure of the Indian government gives states control over several areas of economic activities; agriculture being an important one. In case of Bihar, neoliberal economic policies were not adopted by the state until the mid-2000s. This delayed implementation of neoliberalism and the high economic growth since the late 2000s, must be understood in the context of the socio-political history of Bihar and the economic system that prevailed previously. In 2005, the National Democratic Alliance (NDA); a coalition of Janta Dal United (JDU) and Bhartiya Janta Party (BJP) replaced the incumbent Rashtriya Janta Dal (RJD) led government. The newly elected government had the backing of the traditional elite in the state (Gupta, 2010). Two reforms that the NDA government introduced immediately after coming to power was the repealing of the Agriculture Produce Marketing Committee (APMC) Act; marketizing and deregulating the state's large agricultural sector and adopting an Industrial Incentive Policy to make doing business easier in the state. Several NPM reforms were also introduced in the public finance and administrative areas of the government (Ibid). Unlike popular belief, these reforms were not a voluntary or a self-made decision by the newly elected government; instead, it was a result of or at least it was influenced by the conditionalities imposed by the World Bank as part of the First Bihar Development Policy Loan/Credit (World Bank, 2007).

Change in the political leadership of Bihar and the reforms it undertook immediately after coming to power was greeted with optimism some of the most prominent pro-market publications. The Economist magazine in 2010 exclaimed that Bihar had 'blossomed' under the leadership of Nitish Kumar. The WSJ said that Nitish had 'unleashed a politics of aspiration' in the state. Bihar was a global case study for economic turn-around, akin to a miracle. A generally accept views among various commentators on Bihar's high economic 'miracle' is that it was ushered in through *sushashan* or good governance under the Nitish Kumar led NDA government (Gupta, 2010). Increased sense of security under the new government along with a spurt in construction and telecommunication sectors contributed significantly to the sudden economic growth (Aiyar, 2010). Prima facie, state increase in development expenditure, particularly towards road construction and telecommunication projects seem like a Keynesian state rather than a neoliberal state. However, a critical difference between a Keynesian state and a neoliberal state is that while the former focusses on

transformation along with growth, creating sustainable models of development, the latter focusses solely on becoming a service delivery state (Gupta, 2007). Bihar has been registering double digit economic growth rate for several years now. Strict fiscal discipline i.e., keeping the fiscal deficit low, has been the mantra of the incumbent chief minister ever since he came to power in 2005. His policies focussed on liberalising the economy, slimming the government to make it more efficient and improving the network of roads in the state. However, it did not choose to address the deep-rooted social, political and economic issues that led to the industrial backwardness of the state in the first place. Instead, it chose to apply market principles to structural problems, many of them caused by failures of the markets in the first place.

1970s and 1980s was the decade of great social and political upheaval in the state, referred to as the decades of the 'rise of plebians' by Christophe Jafferlot (Jaffrelot, 2009). A new socialist government led by a backward caste leader gained the political leadership in the state in 1990 and continued to rule the state until 2005. However, the rise of the previously marginalized caste groups also led to conflicts with the previously upper caste dominated sections of the government; in particular the bureaucracy (Mathew & Moore, 2011). Any attempt to understand the current political economic situation in the state must take into account the developments that happened during these fifteen years.

4.2 Neoliberal reforms in Bihar

Economic liberalisation policies ushered in by the Government of India in 1991, didn't prove to be advantageous for the state of Bihar for many years. During the reform era of the 1990s, when the rest of the country's economy registered an average growth rate of 6% in its GDP, Bihar's economy grew at a rate just above 2.5% (P.P.Ghosh & Gupta, 2012). One of the major disadvantages with the state was the insignificant presence of an industrial economy, which was the focus of economic liberalization policies. In fact, the economic growth in Bihar since the 1990s was the lowest among any of the states in India until 2006-07 (Ibid)

It is now widely believed that the Freight Equalization Policy of 1952 had much to contribute towards the loss of revenues and eventually lack of industrialization in the state of Bihar (Sharma, et al., 2012). Under this policy, cost of transporting coal and iron ore was decided solely on the basis of its weight and not the distance that the freight was going to cover. Although the idea was that a factory could be set up anywhere in India and the long-distance transportation of minerals would be subsidized by the central government, it proved to be a

huge bane for coal and iron rich undivided Bihar, because industries, especially heavy industries or electricity production plants were more profitable to be set up near trade hubs like coastal areas. The policy disincentivized establishment of production facilities in Bihar despite having some of the richest mineral resources in the country.

Other than the historical disadvantaged that accrued from the Freight Equalization Policy, **lack of investment in the agricultural sector and dismal performance of the land reforms are two of the most important economic reasons that obstructed the state from utilizing some of the benefits of the economic liberalization policies**. Bihar is predominantly a rural economy, as per the census of 2011, 88.7% of the state's population lives in rural areas. Of the total workforce in the state, 75% are engaged in agricultural or allied activities (GOB, 2021). Therefore, economic reform is inextricably linked to land reforms and reforms in the agricultural sector.

Unequal land distribution is still closely tied to the issue of agricultural productivity in Bihar. Although, rise of the middle castes in the last three decades has been accompanied by their political empowerment as well as economic empowerment, and accumulation of land has been one of the contributing factors in the latter, lower castes have not really benefited from the alteration in land holding patterns. Fragmentation of landholdings among upper castes have also been reported after thirty years of OBC political rule in Bihar but they still continue to be the largest land holders in the state (Sharma, 2005).

Another setback that the state economy received in this intervening period was the bifurcation of the state in the year 2000. Most of the resource generating sectors were transferred to the newly formed state of Jharkhand. Big-ticket private investment stayed away from the state as it was seen as a lawless land where state didn't have the capacity or the intent to protect business interests (Tripathi, 2004). However, perhaps the most important reasons for the failure of the state to undertake economic reforms was its social and political history. The feudal structure that dominated the socio-economic realm in the state for a significant part of the 20th century and the socio-political movements that challenged and partially dismantled those structures are responsible for the economic backwardness of the state.

4.3 Historical factors leading the change from feudalism to semi-feudalism to defused feudalism

In an agrarian state, land becomes the biggest means of wealth accumulation. Historically in Bihar, it is the upper castes who owned significant portions of agricultural land in Bihar. In addition to their social status attributed to their caste position in the caste hierarchy, these caste groups dominated every sphere of Bihar society, including the economic activities.

In colonial Bengal (present-day Bihar was a part of it until 1912), the agrarian economy was structured around three main caste groups: 'twice born' (dwijas) wearers of the sacred thread; peasant castes who did not wear the sacred thread and had to settle for inferior tenancy arrangements and provide free or discounted labour and services; and 'untouchable' castes who were considered 'impure' and were landless and often bonded laborers. The entire zamindari system of colonial land tenure in large areas of north India was underpinned by these caste divisions (Witsoe, 2013). The permanent settlement was first implemented in 1793, Bihar was one of the regions (along with some other areas of Bengal, some areas of Uttar Pradesh, and some parts of Madras) where the zamindars were made the intermediaries for collecting land revenue/rent from peasants and in exchange, they had to pay fixed amount of land revenue to the state. In lieu of that they were free to collect rent from their tenant cultivators or raiyat[13]. Until the zamindari system was abolished, the agrarian structure in Bihar was led by the British state, who gave permanent rights to collect land revenue to the Zamindars, then there were intermediary tenure holders and revenue collectors who were responsible for collecting rent (Samanta, et al., 2013). People who were actually tilling the land were raiyats of different categories decided by their land ownership status. The Zamindars and tenure holders formed the upper class in Bihar. The upper castes had princely estates and after becoming zamindars they had complete political, economic and social control in the state. Upper caste organizations also founded colleges and universities and patronized caste-based educational scholarships. In this way agricultural surplus and rural power was used to strengthen their human capital, and access to government, on the basis of emerging caste networks (Witsoe, 2013). Although, a few of the tenure holders were also from the upper backward castes mainly Yadavs and Kurmis, but largely they were non-occupancy raiyats, traders and agricultural labourers. Lower backward castes were artisans, peasants and agricultural labourers and Scheduled castes were

[13] Occupancy Raiyat Raiyats having right of occupancy in the land held by them. Non occupancy Raiyat Raiyats not having the right of occupancy Under Raiyat Tenants holding land under a raiyat.

predominantly agricultural labourers. The caste hierarchy in Bihar was almost identical to the extent of one's involvement and ownership of land (Samanta, et al., 2013).

The permanent settlement produced an extremely exploitative agrarian structure in Bihar, the worst form of which was the *batai* or the tenants at will system. The *bataidars*, were second only to the landless agricultural labourers who had no security of tenure the landlord could evict him at will. In the *bataidari* system, the landowner bears the cost of all inputs of production except labour, which is provided by the tenant cultivator. The produce is finally divided equally between the landowner and the cultivator (Bandyopadhyay, 2009). Organized resistance against the zamindari system had begun in Bihar in the 1920s; Bihar Pradesh Kisan Sabha (BPKS) was established in 1929 by Sahjanad Saraswati, a peasant leader. It was founded on the belief that class struggle was the only way to liberate the masses, especially the peasants from the 'parasitic' zamindari system (Pinch, 1996). Socialist leaders of the Kisan Sabha, like Jayaprakash Narayan, Ganga Sharan Sinha, Awadheshwar Prasad Sinha and others, had played a key role in bringing about new consciousness among the peasantry in the decades through 1930s and 1940s.

The zamindari system was abolished in 1950 in India and Bihar was the first state in India to adopt a resolution abolishing the zamindari system. Bihar government passed the Zamindari Abolition Act in 1947. In 1948, this was amended and published as Bihar Zamindari Abolition Act (1948). The Bihar Land Reforms Act was passed in 1950 (Samanta, et al., 2013). However, zamindars were allowed to have their private land along with their homestead, which was still huge amounts of land (Sharma, 2005). To mitigate this, the Land ceiling Act was passed in 1962 and in reaction to it the landlords evicted a large number of sharecroppers or tenets from their lands during the 1960s effectively dispossessing them of the only source of livelihood. Even though the law was amended in 1970 to safeguard the interests of tenets by making forceful ejection unlawful and restoration of the land to the tenet, the law remained scantly implemented (Sharma & Wilson, 2002). Several studies have pointed out that even today widespread violation of both the land ceiling laws and the tenancy laws happen in Bihar, as a result land holding has remained concentrated in the hands of few upper caste and OBC groups (Sharma, et al., 2002). The system of tenancy is almost entirely concealed and informal in rural areas, and hence there is no security of tenure and implementation of minimum wages in rural areas is also extremely rare. Under the new tenancy laws, the tenants were allowed to buy the land under their cultivation. However, no financial help or payment restructuring was done

from the state and as a result, only bigger tenants with the ability to pay, could have ownership of land while the rest either became tenants-at-will or agricultural labourers. Therefore, a new group of surplus-hungry landlords and big peasants emerged as the economically dominant classes in rural Bihar along with the dominant upper castes (Sharma, 2005).

However, it must be remembered that the networks of power that the landlords had in their control or had access to, allowed them to continue evading the new law. Even though the government encouraged tenants to but the freed-up land, most peasants, extremely pauperized by centuries of exploitation, had no means to be able to acquire the available and cultivate land. Studies have also shown that the ceiling laws were grossly violated in various parts of Bihar. However, some of the middle backward castes, who were the occupying tenants, or were traders and artisans did manage to acquire more land. Much of the land that was relinquished by the former zamindars was acquired by the tenants from the peasant-caste background, who were not as pauperized and marginalized as some of the other backward castes who were entirely landless and didn't have the resources to take over the newly available land. Yadav, Kurmi and Koeri castes emerged to benefit the most, they had small landholdings of their own even when they were tenants of large zamindars. However, the material change in the land ownership and wealth of these cultivator castes didn't match with their social and political power in the state. The conflict between these upper backward castes and the upper castes in the state had a long history but for the first time the upper backward castes had the material resources to challenge them significantly and strive to dethrone them from the political leadership of the state.

Effectively, Bihar's agrarian structure remained exploitative despite all the legislation that were passed. However, over the years, there have been some significant shifts in the class position of the various sections of rural society. The elimination of the revenue collection intermediaries considerably weakened the feudal structure, but didn't not break it. A significant portion of the upper middle castes, the majority of the upper caste non-occupancy raiyats of the former zamindars, and all the upper caste tenure-holders transformed into big peasants with complete control over the villages who abused the peasantry through sharecropping and money lending. The largest landowner in the village maintained unquestioned control over the other villagers and continued to be consulted on subjects pertaining to the management of the community's affairs, such as setting local agricultural wages, land rights, and other related concerns. This exploitative and anti-growth structure was termed by Pradhan H Prasad as Semi-feudal and is

used by several commentators to describe the social structure in Bihar even today (Sharma, 2005). Despite the reduced political representation, upper caste groups in Bihar continued to have a stronghold over the political economy in the state even today as they still own most of the land, still have the social capital that they derive from the varna system and they are well-represented in the state's bureaucracy (Robin, 2009).

4.3.1 Contracting culture in Bihar:

The choice of contracting known locally as *thekedari* system comes naturally to the state from its agricultural production system. Tenancy-based farming is highly common; more than 30% of the cultivable land is leased from other farmers. *Bataidari* (Sharecropping) is the most prevalent from of this type of production system in the state. According to NSSO 587 round, 50% of the total leased land in Bihar is cultivated on the concealed tenancy where produce is shared by the landowner and the cultivator (NSSO, 2021). The still prevalent feudal systems of rent seeking like the *batai* system gives upper caste landowners hassle-free income and social status. Land is not a factor of production but a symbol of power, influence and status. They cannot think of themselves as cultivating peasant farmer (Bandyopadhyay, 2009).

In the past, tenants have been thought of as an institution where small farmers, in general, seek to lease in land and large farmers, in contrast, are interested in leasing out operations. Some agricultural workers transition to non-farm occupations or relocate to metropolitan regions in search of employment in a fast-changing development-based economy. They are prepared to lease their land to renters because they are unable to develop it themselves. In India, it is typical for landowners to lease their property to cultivators. Such contracts even if made orally are considered as lease contracts. Tenant farming is a type of agricultural system where landowners supply their land, operational capital, and management, while tenant farmers provide their labour, as well as the necessary capital and management, in accordance with the agreement. More informal, unsafe, and ineffective tenancy farming. Informal tenants lack access to institutional loans, insurance, and other support services, as well as legal sanctity (Bandyopadhyay, 2009).

The culture of contracting and outsourcing has been at the centre of the agricultural economy in Bihar. Upper castes along with a few dominant backward castes have used landless small landholding backward castes for cultivating their lands. A state where close to 90% of people live in rural areas where their lives are shaped by the agrarian production system; the

contracting culture permeates to all other facets of the society as well. Therefore, the idea of PPPs which is significantly informed by the principles of contracting.

4.4 Rise of Middle Castes

Bihar was also the cradle of the socialist movement in the country. There was a class consciousness that was stirred by the leaders of the BKPS in the pre-independence decades in Bihar. In the post-independence decades, socialist leaders particularly Jai Prakash Narain and Ram Manohar Lohia recognized the congruence between the class and the caste structures in Bihar. A small minority of upper castes dominated the political, economic, social spheres in the state and strongly entrenched themselves as the upper class. The political impact of these struggles precipitated for the first time in 1967 when the upper caste dominated Indian national Congress party lost the state elections for the first time in 1967. The share of upper caste MLAs began to decline in the Bihar assembly; compared to 1952 it had more than halved by 1995. However, they still remained significantly over-represented (Jaffrelot, 2009). Number of OBC legislators more than doubled in the same period; of which Yadavs were the biggest gainers whose representative more than trebled. However, the scheduled castes' representation remained the almost the same; from 14 MLAs in 1952, they had only 15 in 1995. A turning point in the history of this power shift was the Mandal commission; in response to the opposition from upper caste groups against a 27% quota for OBCs, there was a wave of counter-mobilization by OBC leaders led by Dr. Ram Manohar Lohia. This led to a sudden rise in political awareness in the OBC community in Bihar (Jaffrelot, 2009). Perhaps the most popular and outspoken face of the struggle against upper caste dominance in Bihar was Lalu Prasad Yadav. His political position was unequivocally against the dominant upper castes. His poll slogan of *'Bhurabal saaf karo'* called for the elimination of the dominance of Bhumihar, Brahmin, Rajput and Kayastha in the state. "Lalu Prasad Yadav gave credibility to his rhetoric by refusing to recruit members of those upper castes into the public service, and by maintaining very close political control over officers already in service…the costs, knowingly incurred, were loss of administrative capacity and, indirectly, sacrifice of fiscal transfers from Delhi" (Mathew & Moore, 2011, p. 20).

While the Lalu era conspicuously focussed on displacing upper castes from Bihar's social, economic and political life; it had two major shortcomings. One, the disempowerment of upper castes was not to the end of redistribution of political, social and economic power and resources. Yadavs, who were the main beneficiaries of the land reforms in Bihar earlier also

gained the most from the political leadership of the state. Most lower caste groups failed to derive significant material benefits during these years but they certainly gained a political voice; what they undoubtedly got was *izzat* (respect) in the society (Witsoe, 2016). Lalu Yadav had famously said about his contribution as chief minister; '*swarg nahi swar diya*', meaning I did not give them a heaven but I did give them a voice (Ibid). Two, economic development was not even on the government's policy agenda. RJD popularized the slogan '*vikas nahi samman chahiye*', signifying its government's priorities (Mathew & Moore, 2011). Scholars have argued that RJD intentionally weakened the state institutions that were dominated by the upper castes, allowing them to deteriorate until they became dysfunctional (Witsoe, 2013). Santosh Mathew has described this Lau era policy of either taking the control of state institutions back from the upper castes and give it to the backward castes or else allow them to crumble by sheer administrative neglect was purposeful and by design (Mathew & Moore, 2011).

The newly elected backward caste political leadership of Bihar had little incentive to reform the upper caste dominated public institutions, which had come under severe funding stress due to government's neglect as well as the fiscal discipline and austerity measures that were implemented by the central government after the 1991 economic reforms. The debilitation of the public sector in the state did lead to a partial displacement of the upper caste control over the sector. Under RJD rule, access to subsidized credit from cooperative banks by the upper castes was reduced, they were cut off from sources of patronage and 'commissions' that they had long enjoyed through the control of development funds. But most significantly severance of the networks with politicians and the police, which had enabled them to maintain and enforce the exploitative sharecropping arrangements, have access to low wage and often free labour etc, weakened the upper caste's control over the public sector. However, the institutional destruction targeted at hindering the upper caste dominance was not accompanied by creation of alternate institutions that would have been more inclusive and benefitted the people living on the margins for centuries. While caste-based political mobilizations destabilized the institutions of governance and state-directed development, this also catalysed a meaningful, although partial, empowerment of lower castes. "The politics of caste empowerment, as well as the many failures of the Bihar government became embodied for most people in the political figure of Lalu Prasad Yadav, a lower-caste leader who challenged the hegemony of Bihar's upper-caste elite and who consistently dominated politics in Bihar from the time when he became chief minister in 1990 until the electoral victory of the rival NDA in 2005" (Witsoe,

2013, p. 300). Therefore, during the Lalu years, the governance approach was to transfer more and more power from state bureaucracy and government officials to elected politicians. "This caste-divide between elected leaders and recruited bureaucrats was the socio-political basis of the breakdown of governance during RJD rule" (Witsoe, 2013, p. 302). While backward castes were able to replaces upper caste dominance in political representation, a similar transfer of power couldn't happen in the bureaucracy.

4.4.1 The bureaucracy and political conflict

The rise of upper OBCs in Bihar was apparent in the number of political representatives that were elected from these castes. Number of MLAs from the backward castes more than doubled from 1985 to 1995; half of the MLAs in the state were from the backward castes in 1995. In the same time-period, the number of upper caste MLA more than halved. However, owing to their improved educational status, upper castes continued to dominate the state's bureaucracy. More than 60% of IAS officers in Bihar were from the upper castes in 2002. Yadavs specifically had 27.4% MLAs in the state's legislative assembly in 2002, whereas the number of Yadav IAS officers was merely 1.6% (Jafferlot, 2000).

The newly elected backward caste political leadership in Bihar had little incentive to strengthen or reform an inefficient public sector dominated by upper caste officers and employees. While the backward caste political leadership of the state, allowed the public institutions to wither by reduction or withdrawal of funding, not doing new recruitments and display a general disinterest in the survival and growth of the public institutions as they were perceived to be controlled by the upper castes. Decision making was centralized to further marginalize the upper caste administrative structure, frequent transfers, increasing political interference in administration and putting backward caste officers in key positions. Administrative postilions were left vacant for years if suitable backward caste officers were not found. The weakening of governance during the RJD rule and weakening of state institutions is generally attributed to the conflict between the backward caste political leadership and the upper caste bureaucracy. The caste divides between elected leaders and recruited bureaucrats was the socio-political basis of the breakdown of governance during RJD rule (Witsoe, 2013).

Weakening of state institutions did lead to a dislodging the upper caste control over them, but only partially. State's patronage in terms of control of development funds, or subsidized credit, protection from criminals etc that the upper caste landed elites had enjoyed previously, were severed. The state machinery that the upper castes used to maintain the exploitative labour

relations and enforce the discriminatory and exploitative sharecropping system was removed. It became less profitable for upper castes to maintain a profitable agricultural system.

A few backward castes have benefitted from a skewed redistribution of political and social power in the state. this meant that the loss of upper caste hegemony in the state did not result in redistribution of that power but rather new caste groups with access to political power managed to capture the released resources. These groups not only became stronger politically but increase in material possession also significantly increased their social status. The system of possession and exploitation previously controlled exclusively by the upper castes, was now also being used by these powerful backward castes.

It important to note that the state did not take any interest in developing the markets as most private economic interests were controlled by the upper caste. Private sector was neither patronized nor regulated by the state, conditions necessary for the spawning and growth of the market such as physical infrastructure, economic incentives, reliable legal system etc were simply not encouraged by the government. The caste conflict, which led to the collapse of the state's public institutions also prevented the state from adopting policies that would ensue proper development of private markets. The reason behind not patronizing market forces was also the backward vs upper caste conflict. As discussed in previous chapters, markets do need active patronization from the state in order to develop and grow. The control over land and the ensuing material accumulation by the upper castes meant that most private economic activity was also controlled by them and any attempt by the state to encourage private businesses would end up being hegemonized by the upper caste and upper-class people.

4.4.2 Intersection of interests: Politics, Bureaucracy and International Aid

The political-bureaucratic relationship in Bihar took a 360 degree turn with the Nitish government in Bihar. While bureaucracy was neglected, side-lined and to some extent punished by the political leadership for its upper caste character during the Lalu regime; Nitish kumar opted to rely more on bureaucrats than his own cabinet colleagues to govern the state. While any expenditure above Rs. 2.5 lakhs had to be improved by none other than the CM himself during the Lalu years; in the Nitish government as part of the financial reforms, expenditure up to Rs. 2.5 crores could be approved by the department secretary. Expenses above Rs. 20 crores needed CM's approval. Frequent transfers of civil servants were a tool used during the Lalu years to exercise control over the functioning of the state's bureaucracy. Whereas, as soon as coming to power, Nitish Kumar stabilized the tenure of civil servants by limiting the total

number of transfers at 10% of the total number of civil servants in a department. Bihar Administrative Reform Commission (BARC) was set up in 2007 to improve the working of the civil service, including rationalization of departments, downsizing, controlling premature transfers, and administrative delegation.

Nitish's penchant for using bureaucracy rather than the executive to govern the state stemmed from the following factors. He could evade the corruption that beleaguered the executive and legislative structure in the state. Elected representatives in Bihar were and still are hugely infamous for being corrupt. Nitish picked officers who had a clean record and were known to be good administrators. The proximity that these officers had with their colleagues in ministries with the GoI also gave them an advantage over legislatures. Even today, Nitish Kumar is known for having to core team of bureaucrats on whom he relies heavily for government policy and program implementation (Jha, 2021).

Perhaps the most significant impact of having bureaucrats in key positions was the access to international development funds. These officers had worked with development partners directly or indirectly in their previous assignments with the central ministries. One key bureaucrat who had been associated with DFID who was working closely with the Bank during those years was the then principal secretary of the state Mr. Ahijeet Sinha. It is claimed that it was the proximity that Mr. Sinha had with the DFID that enabled the agency to fund a Rs. 1000 crore program in Bihar. Mr. Nand Kishore Singh, who had served at key positions in the MoF, GoI, was the secretary of former prime minister Atal Bihari Vajpayee, was member of the planning commission and had an extensive experience of working with international development agencies was appointed as the Deputy Chairman of the Bihar State Planning Board in 2006. The policy document titled "Bihar-Approach to 11th Five Year Plan", which was conceptualized by Mr. Singh. Recommendations from this report were found to be frequently cited by the world bank loan documents that were published subsequently. In the preface of the report itself, Mr. Singh wrote that PPP should be incentivized in the state and be used as a strategy to strengthen infrastructure (GOB, 2006). It recommended extensive use of the PPP model in education and health sector. It argued that private investment in departments like pathology, radiology, maintenance and ambulatory services; it also recommended outsourcing of APHCs to private firms. For setting up of medical colleges it recommended that

> "Setting up of medical colleges through PPP mechanism shall be encouraged and the government will facilitate in the provision of land, water, power and will also share the

cost of preparation of the bidding document. The state will go by the single window approach to speed up the procedures" (GOB, 2006, p. 102).

In the next few sections of this chapter, it becomes evident how the recommendation of this committee was actually followed in applying the PPP model in healthcare in the state.

International development agencies became major stakeholders in the development sector in Bihar as soon as the change in political leadership came into effect. These development partners not only provided financial aid in terms of development funds and loans but also provided non-lending technical assistance. WB, DFID and ADB were the three major development partners in Bihar during the initial years of Nitish Kumar's government. The three were working in coordination with each other and areas of intervention targeted by each were well-defined. Overall strategic leadership did lie with the World Bank though. A coordinated approach by the three development agencies in Bihar in the mid to late 2000s appears unique to Bihar. A consensus was there between the government of Bihar and the three development partners that physical infrastructure development like roads, power and agriculture was ADB's responsibility; infrastructure in education, social protection, rural livelihoods was to be taken by the world bank and reforms in health infrastructure was to be done by the DFID. World bank was to play a leadership role in the non-lending technical assistance, basically advising the state on the kind of policy and governance reforms that were required.

Public institutions were weakened by years of neglect by the government during the 1990s. the rebuilding of these institutions taken up by the newly elected NDA government in 2005 was greatly influenced by development partners who for the first time began long term investments in the development sector in the state. Public policy in Bihar after 2005 and the direction that the development project was headed was steered by these institutions led by the World Bank.

The NDA government took the role of a definitive neoliberal state in the role of the state by focussing itself on creating favourable investment climate for private capital, focussing on protection of private property rights. As any neoliberal state should subject society to the rule of law but should not intervene in the functions of the market; it should also provide key services to facilitate the growth of market wherever it is nascent; government of Bihar, supported by multilateral finance institutions, acquiesced itself to this role. In many ways, the new government model of Bihar conformed to the World Bank's imagination of an 'effective state' as enunciated in the World Development Report of 1997 titled "The State in a Changing

World". The growing gap between expectations from a state and its capability to fulfil those expectations, as per the report, could be reduced by taking some of the 'burden off the state' (World Bank, 1997, p. 3). Although the report did accept that relieving the state off of some of its core functions and relying more on private firms and citizenry alone could not be enough in itself and state's capability must also be increased. It added the state need not be the sole provider of public goods and social services and a range of active government initiatives along with carefully designed regulations can 'enhance the growth of markets' (Ibid).

4.5 Change in upper class constitution in Bihar: encouraging market reforms

Bihar has witnessed a significant rise in the political status of the OBCs since the 1990s that has also had a positive impact on the status of scheduled castes in the state, although not as much as the OBCs. It must be remembered that the upper castes are still the most powerful and resourceful group in the state. Their caste privilege continues to help them in maintaining their dominance on the economic, social as well as the political spheres in the state. the private health sector in Bihar is no exception to the upper caste dominance. Upper caste privileges, particularly land ownership, helped them to channel the agricultural surplus and the socio-political power into strengthening their human capital, increasing access to government machinery and resources and reinforcing the production system that allowed them to maintain their position of power. Caste based organizations established educational institutions and patronized caste-based scholarships towards that end; the nexus between landowning elites, politicians, bureaucrats and business people was held together and strengthened by their upper caste background.

Until independence upper class in Bihar was invariably comprised of upper castes. However, in the post-independence decades partial land reforms that happened in the state saw the entry of cultivator or middle castes who benefited from the land redistribution. These castes were relatively better-off than the landless peasants and were able to acquire more land relinquished by the zamindars. Their position was further strengthened after the 1980s when strong political movements gave them the political leadership in the state. Control over the political leadership of the state and increase in landholding led to significant improvement in the financial status of these middle castes. Their increased participation in economic activities also contributed to accumulation of surplus for them. In a way, due to an improvement in their social, political as well as economic status, these castes groups broke into the upper-class category. They also adopted the upper-class characteristics by refusing to follow the policy of redistribution of

resources across all caste groups in the state. This is evident in the more or less unchanged living conditions of some of the most marginalized castes in the state.

A survey of 9000 households conducted by the World Bank's Jeevika program in 2011 presents a more nuanced picture of income as well as wealth inequality in the state. It becomes clear that there are castes within both SC as well as OBC categories, which are significantly worse off than other castes in the same categories as well as other castes. Castes like the Koeri neither have as much as land as Yadavs and Kurmis nor their income as high as them. Kurmis do have income parity with Yadavs but their landholding is almost half of them, indicating the possibility that their employment status is better than the Yadavs.

Table 4: Income and land inequality in Bihar

Caste	Average monthly per capita expenditure (in rupees)	Average land ownership (in acres)
SC- Chamar	634.5	0.146
SC- Dusadh	601.8	0.27
SC- Mushar	560.9	0.075
SC- Dom	662.5	0.015
SC- Pasi	639.5	0.534
OBC- Yadav	603	2.266
OBC- Koeri	575.14	1.437
OBC- Kurmi	639.9	1.18
UC- Brahmin	701.3	1.533
UC- Rajput	687.2	2.439

Source: (Joshi, et al., 2018)

Two of the four upper castes surveyed in this report have clear and significant advantage over all other castes but the Yadavs both in terms of income as well as land ownership. For example, the average land ownership of Rajputs surpasses the land ownership of Doms; one of the most marginalized castes in Bihar by an astonishing 160 times.

A joint study by the London School of Economic, University of Oxford and International Growth Centre reported that it was only since 2010, that is after the creation of the Bihar Mahadalit Vikas Mission, that the land distribution among the most backward castes began with a serious commitment (Kumar & Somanathan, 2016). Some of the most underprivileged

and marginalized castes like the Mushar, Dom, Chamar and Pasi continue to be neglected. Government of Bihar conducted a census of Mahadalit households in the state in 2009-10. In that survey it was reported that 17% of the Mahadalit families did not have a home; which is more than 2.16 lakh households. Less than 1% of the Mushar and Dom households had someone literate in the family (Jha, 2017). Anthropological studies as well as surveys by development studies have report that Mushhars are considerably disadvantaged than other scheduled castes. Their per capita income, land holding and consumption are lower than any of the other caste group in Bihar.

The agricultural sector in Bihar is central to the overall economic performance of the state, nearly 75% of the state's workforce is employed in the agricultural and allied sectors alone (GoB, 2021). The contribution towards state's GDP was 18.7% in 2019-20 (ibid). Distribution of landholding patterns in Bihar also indicates the extreme inequality in land ownership in the state.

Table 5: Distribution of land ownership in Rural Bihar

	Number of Households		Land	
	2003	2018	2003	2018
Landless	na	3.40%	na	0
Marginal	89.40%	91.80%	42.07%	62.70%
Small	7.10%	4%	25.29%	21.30%
Semi-medium	2.70%	1.10%	18.53%	11.40%
Medium	0.70%	0.00%	9.56%	2%
Large	0.10%	0.00%	4.63%	2.90%

Source: (NSSO, 2021) and (NSSO, 2006)

Category of landholding	**Size of holding**
Landless	less than or equal to 0.002 hectares
Marginal	more than 0.002 but less than or equal 1.000 hectares
Small	more than 1.000 but less than or equal to 2.000 hectare
Small-medium	more than 2.000 but less than or equal to 4.000 hectares
Medium	more than 4.000 but less than or equal to 10.000 hectares
Large	more than 10.000 hectares

Source: (NSSO, 2021)

Land ownership data from the National Sample Surveys of 2003 show that 4.43% of the total cultivable land in the state was owned by a small percentage of people, 0.10%. Although the situation has improved by the time another survey was conducted in 2018, it is still remains extremely unequal. 2.9% of the land continues to be held by a statistically insignificant portion of households in the state. Similarly, 1.1% of the households own 11.4% of the land and 4% of the households own 21.3% of the land. The status of households that own less than one hectare of land and fall within the landless and marginal farmers category continues to remain the worst of all landholding segments. Even though they constitute 95% of the population, they own 62.7% of the land. It is clear that even though medium to large landholdings have declined from 2003 to 2018, the freed-up land has not gone to small and marginal farmers as much as it has gone to small, medium and semi-medium farmers.

The profession of medicine historically has been almost entirely controlled by the upper castes and despite the change in the caste dynamics in the past few decades, they continue to be disproportionately dominated the private health market in the state. For instance, the districts of Gaya, Aurangabad and Nawada have the largest percentage of SC population in the state at 30.39%, 25.47% and 24.10% according to the socio-economic caste census of 2011. However, when it comes to the number of practicing doctors; their percentage is 1.8%, 1.9% and 5.4% respectively.

Table 6: Caste composition of private Doctors in three Districts

	Gaya		Aurangabad		Nawada	
Upper Cate	210	63.4%	71	67.6%	26	47.3%
OBC	23	6.9%	2	1.9%	5	9.1%
SC	5	1.5%	2	1.9%	3	5.5%
ST	4	1.2%	0	0.0	0	0.0
Muslims	35	10.6%	5	4.8%	1	1.8%
Unclear	54	16.3%	25	23.8%	20	36.4%
Total	331		105		55	

Source: IMA Bihar website[14]

[14] https://imabihar.org/membership-directory/
The categorization was done on the basis of the last names of doctors that are enlisted on the IMA Bihar's member directory. Using caste specific last names is a prevalent practice not only in Bihar but also in India.

The category of doctors that is named 'unclear' are the ones who had caste neutral surnames like 'Kumar'. It is not a norm but generally the surname kumar has been seen to be used by upper castes, especially Bhumihars and Kayasthas. So, in all probability the percentage of upper caste doctors as reflected in this table is the most conservative estimate and is most likely to be higher. It is evident that the private interests in the health sector in Bihar lie with the interests of the upper castes. It benefits them to have a weak public health system where people have no option but to turn to the private market seeking healthcare. Partnerships with the state serves these interest groups in two ways; one, state assumes the role of a consumer with a large and captive demand contributing to the growth and strengthening the private markets and two, state becomes increasingly more dependent on them.

4.6 NRHM's impetus for PPPs in Bihar

The advent of the National Rural Health Mission (NRHM) in 2005 is a cornerstone in the public health landscape of Bihar as far as public-private partnerships are concerned. NRHM, reshaped and renamed as the National Health Mission (NHM)[15] in 2013 opened up formal channels for tapping the potential of the private healthcare sector more systematically and significantly than before (Gupta, 2009). Bihar was one of the 'Special Focus States' of the Mission. The institutional capacity of health system in Bihar was abysmal in 2005. A lot of its limited resources was being spent on creating and running planning and monitoring processes, ensuring proper reporting mechanisms are in place and functional, convergence of different program activities etc. These were in addition to the core health activities that were added on as part of the NRHM strategy on a dilapidated health system. Unsurprisingly, the state was not able to spend the allotted funds under NRHM. Public-private partnerships at this juncture provided a win-win solution to all stakeholders; it was part of the NRHM strategy so the GOI was amiable, state government that was providing 10% of the healthcare by itself was relieved to share burden of improving health indices and simultaneously be able to increase spending from the NRHM pool and the private sector was anyways eager to be formally recognized as a partner of the state in its endeavour to improve public health. Bihar was particularly receptive to the idea of PPP as their public health system was so enervated that it lacked the capacity to spend significant amounts of the NRHM funds allocated to it. In just a few years PPPs became the

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Manjhi, *Paswan*, *Ram* etc. are titles used by SCs; *Mishra*, *Jha*, *Singh* etc by UCs; *Yadavs*, *Rai*, *Mahto* etc. by OBCs. In case of any lack of clarity, the name of put in the 'unclear' category.

[15] GOI in a decision dated 1st May 2013, approved the launch of NUHM as a Sub-mission of an overarching NHM, with NRHM being the other Sub-mission of National Health Mission.

preferred choice not just for support services like cleaning and laundry at health facilities and ancillary services like waste management, ambulances, but for a whole range of services like pathology and diagnostics, healthcare services like dialysis, contracting out of specialized care, outreach services, facilities-based RCH services and managing and running PHCs (SHS , 2008). NRHM's significant role in spawning and strengthening PPPs in special focus states, particularly Bihar, has been recognized and recorded by health system professional working in the state. They argue that NRHM provided an impetus or rather necessitated the growth of PPPs in Bihar and its financial mechanisms, planning and execution of projects eventually led to the emergence and proliferation of PPPs in states like Bihar (Gupta, 2009) (Das, 2007). The program also promoted public-private partnership model for greater community reach and more decentralized implementation. It provided an opportunity for the state and the market to arrive at an agreement to involve private sector partners; both for-profit and not-for-profit and raise their status as stakeholders in the delivery of healthcare.

State of Bihar was one of the first few states to constitute a State Health Society (SHS) immediately after the launch of NRHM in 2005.[16] The SHS was expected to be an additional managerial and technical resource to the state's Department of Health and Family Welfare for the implementation of the NRHM. This agency receives the NHM funds from the Ministry of Health and Family Welfare, Government of India and is responsible for its disbursal, management, accounting and reporting to NHM.[17]

The NRHM framework for implementation document is rife with reference to PPPs and their crucial role achieving the goals of the mission, which were to bring about 'dramatic improvements in the health systems and health status of the people' particularly for those living in the rural areas. Although the NRHM strategy was bullish on partnerships with the NGOs and the non-profits only, it did set the platform for PPPs to become a preferred mode of introducing health interventions in states. RCH II program was started with the objective to improve three main health indicators; total fertility rate, infant mortality rate and neo-natal mortality rate. Establishing partnerships with private health providers (for-profit) as well as with NGOs, civil society organizations and religious organizations (not for-profit) was one of the key strategies of the RCH II initiatives in Bihar (SHS Bihar, 2006). The explosion of PPPs

[16] The society by-laws were resolved on 07-06-2005, just two months after the launch of the NRHM launch of the framework of implementation document.
[17] http://statehealthsocietybihar.org/aboutus.html

in the health sector in Bihar post-NRHM can be gauged from the fact that some twenty-six new public-private partnerships were started in during 2005-08 (Gupta, 2009).

The year 2005 is a significant for this study on Bihar for two reasons; one is the launch of the NRHM program in 2005 and the second is the change in political leadership of the state after 15 years. The periods before and after 2005 are starkly different in terms of administrative and governance changes, market sentiments, public perception and economic growth. Although many of the structural challenges that the state faced before 2005, still remained during the post 2005 era, a distinct increase in economic growth is a defining characteristic of the time period. Implementation of the NRHM program meant a sudden and quantum increase in the central funding towards healthcare.

4.7 The role of Development Finance

Bihar has been one of the focus states of most of the development finance institutions for the last two decades receiving significant amount of funds in the health sector particularly after 2005. Multinational developmental organizations play an extremely important role in shaping the public health landscape in any low-income economy. With their grants, they have the power to significantly influence the health policy in those economies according to their health priorities, which often does not align with the local public health necessities. Particularly in the last two decades a rise and proliferation of private health alliances and foundations has completely transformed the global health landscape and their impact is evident at the micro level in places like Bihar. These organizations advocate a top-down techno-managerial approach to complex public health problems, often applying the strategies that business apply to overcome the challenges they face in running a successful organization (Birn, et al., 2017). They are a part of a wider shift, in which non health and non-state actors such as the World Bank, private foundations and partnerships have challenged and undermined the of multilateral institutions like the WHO and UNICEF as world health leaders (Brown et al. 2006). This shift is steered by a global rise of a market led public health model facilitated by the strengthening neoliberal economic ideology. The World Bank’s policy documents on Bihar were pushing for public-private partnerships in healthcare in Bihar by mid 2000s. In one of its earlier reports, the Bank assessed the private sector in healthcare in Bihar. it observed that;

> “There is as yet no broad framework for incorporating the private sector into health care delivery. However, government officials are open to considering possible ideas and

models for increased participation for the private sector including public funding for private provision.” (World Bank, 2005, p. 20).

The same document also recommended for the outsourcing of PHCs, which the state government undertook also but eventually gave up after repeated failures. Despite acknowledging that the private health sector increases the financial burden of healthcare on people, the Bank went on to claim that;

> “When it comes to health care in Bihar, affordability is not a major issue. Anecdotes recount that Biharis care about three things in life; marriage, health, and education. Several surveys have confirmed that, despite high levels of poverty, Biharis are willing to pay for access” (Ibid, p. 9).

Although prima facie, the statement does reflect the health seeking behaviour of people not only from Bihar but anywhere else. People do end up selling assets, exhausting their live savings and taking debts in order to ensure their health and that of their loved ones. However, its never a choice for them, they are compelled to do it because of a non-functional public health system. The World Bank’s own diagnosis of Bihar’s lack of economic development has been criticized for limiting itself to absence of adequate infrastructure and lack of economic incentives in the state, ignoring the lack of agrarian and land reform in the state (Wilson, 2006).

In the World Bank’s Doing Business in India Report of 2009*, Bihar was portrayed as a market that is more conducive, encouraging and free from state’s intervention than many other states in India. Patna was ranked at the second position, just below Delhi in the list of 17 cities where it was easiest to start a business. It was ranked higher than Indore, Jaipur, Kochi and Mumbai in terms of ease of getting a construction permit. Export and import were easier in Patna than in Hyderabad, New Delhi, Noida and Gurgaon* (World Bank, 2009).

The ‘limited state’ approach with independent markets was also in consonance with Bihar’s own socio-political contestations and the highly unorganized and unregulated, especially in the healthcare sector. Bihar’s economic growth miracle was not unaffected by the domestic socio-political structures of power and their internal contestations. State policies are also an outcome of these contestations where the dominant class or group steers it into a favourable direction. The health sector in Bihar, as it has been demonstrated in the previous chapters, has been almost uniquely unorganized, dominated by private practitioners and small nursing homes. Even today

there are only a small number of large hospitals in the state and only one corporate hospital; and even they have come up in the last ten years only.

State Investment Promotion Board was set up in Bihar in January 2006 and a new Industrial Incentives Policy was adopted in the same year by the new NDA government. The new policy gave further financial and regulatory incentives compared to the Industrial Policy of 2003 like concession on land, reimbursement of fees, exemption of stamp duty, corpus for revival of sick/closed unites etc. Industrial units wanting to expand or modernize were also eligible for financial incentives and majority of the quality certification costs by any of the industrial unites were borne by the state government. An IT mission was also launched to promoted the development of the IT sector in the state; several rules and regulations were relaxed to provide incentives/relief to the IT sector in the state. All these new policies were drafted in consultation with the Bihar Chamber of Commerce, Bihar Industries Association, Confederation of Indian Industries and other associations (Gupta, 2007).

4.7.1 Structural Adjustment in Bihar:

The world bank was engaged in project-based funding in Bihar since the 1960s. The Son Irrigation Project intimated with WB money in 1962 was the first one. Most investments by the Bank were fixed-term infrastructure development projects where in Bank provided a loan and the state of Bihar repaid; there was no policy level involvement. However, 'The First Bihar Development Policy Loan/Credit' (BDPL) was the first time that the Bank initiated a multi-pronged engagement with the government of Bihar. A USD 225 million (Rs. 945 crores[18]) assistance had a 35-year maturity period and came up with a set of conditionalities (World Bank, 2007). These conditionalities needed to be fulfilled by the government of Bihar in order to receive subsequent instalments/traches from the Bank. Four core area that the BDPL hoped to reform were Fiscal and Public Finance Management reforms, Governance and Administrative reforms, Investment Climate reforms and Social sector specific reforms. Many of the administrative and policy decisions taken by the Nitish Kumar government in Bihar can be traced back to the recommendations made by or conditionalities necessitated by the BDPL. The administrative reforms introduced in the bureaucracy that were mentioned previously were a pre-condition for the release of the second tranche of BDPL credit. The fiscal and public finance management reforms as mandated by the conditionalities required fiscal deficit to

[18] Converted using the dollar rupee exchange rate of 2007. USD 1= Rs.42

remain 3% of the GSDP (World Bank, 2007). Following which, the Government of Bihar enacted the Bihar Fiscal Responsibility and Budget Management (FRBM) Act in 2006, seeking to contain the fiscal deficit to less than 3%. However, as Bihar was a revenue deficit state that relied heavily on central government grants; reduction in deficits meant reduction in expenditure. Therefore, no significant investments were made to improve the dilapidated condition of the healthcare sector other than the funds that were given by the GoI or by the development partners. The Bank also recommended that since the state was revenue deficient, PPPs should be used for infrastructure development in the state:

> "GOB is keen to harness PPPs to improve the delivery of infrastructure services across various sectors as it would be more efficient and also because the expenditure through exchequer alone will not be sufficient to mobilize the large scale investments required to bridge the infrastructure gaps…The Bank will work to strengthen the policy and legal frameworks governing infrastructure PPPs in the state and build capacities for undertaking PPPs" (World Bank, 2007, p. 4)

To encourage economic growth in the state, the loan document recommended changing the legal and policy landscape in the state towards enabling more PPPs.

> "The investment climate reform component supports a more conducive legal and regulatory framework to promote rapid clearance procedures for establishing enterprises and improving the legal and policy environment for enabling Public-private Partnerships (PPPs)" (World Bank, 2009, p. 2).

Parallel to the financial assistance under BDPL, a non-financial technical assistance program named the 'Bihar Capacity Building Technical Assistance (BCB TA) program' was also started. The technical assistance program was funded by the DFID Trust whose member were the World Bank, DFID and ADB (World Bank, 2007).

The Public-private Infrastructure Advisory Facility, a global fund that facilitates the involvement of private sector in development programs was established in 1993 by the World Bank and the Asian Development Bank. Along with the non-financial technical assistance provided by DFID, the PPIAF supported the Bihar government in facilitating the growth of PPPs in Bihar (Ibid). Push by development agencies towards increased private participation aligned perfectly with the state's own proclivity for contracting in different forms that stemmed from the agrarian production structures in the state.

Jeevika was another big-ticket project in the social sector in Bihar for the Bank that was implemented in 2007. The Bihar Rural Livelihoods Promotion Society (BRLPS), an autonomous body under the Department of Rural Development, launched Jeevika with the support of World Bank. The Norway India Partnership Initiative (NIPI) had also started a partnership with the GoB along with United Nations Development Programme (UNDP) in 2008 (Darmstadt, et al., 2020). Department for International Development (DFID) UK had launched a five-year program worth almost a thousand crores named Sector-Wide Approach to Strengthening Health in Bihar (SWASTH) to strengthen health, nutrition, water and sanitation systems across Bihar in 2010. Maternal and child health has been a focus area of DFID funding in Bihar since the advent of NRHM. In the RCH II program, DFID and the World Bank together shared 33% of the funding contributions from 2006-12 (World Bank, 2012). The total funding for this program was more than 75% of the funds that the DFID-WB team had allocated for the RCH II program for the whole country, indicating how significant this program must have been for DFID as well as for governments of India and Bihar (Ibid)

Sector Wide Approach to Strengthen Health (SWASTH) was a partnership between government of Bihar and Department for International Development (DFID) UK. Funded by DFID, the program included three government departments; Health and Family Welfare, Social Welfare, and Public Health Engineering. Goal of the program was to improve the health and nutritional status of Bihar by 'reducing maternal deaths, child deaths, under-nutrition and unwanted pregnancies.' DFID provided funds equivalent to Rs, 1000 crores from 2010-2016 under the aegis of the SWASTH program. The programme has both-Financial Assistance and Technical Assistance components and a technical Assistance support team called Bihar Technical Assistance and Support Team BTAST was formed by DFID to support GoB to prepare the design and implementation of the program. BTAST was a consortium of DFID, CARE India, Options Consulting UK and IPE Global India (NRHM, 2012).

4.7.2 Entry of the BMGF

The pivotal event in the history of healthcare PPPs in Bihar was the entry of the Bill and Melinda Gates Foundation (BMGF) in 2010. BMGF partnered with the Government of Bihar launch the Ananya program to improve reproductive, maternal, newborn and child health and nutrition (RMNCHN) outcomes. NRHM and the DFID funded program were already focussing on these areas in the state. Unlike the previous development agencies, who released the funds to the state treasury, the Gates Foundation chose to completely bypass the state machinery as

far as the financial control and release of funds is concerned. Neither the state treasury nor the state health society were used as conduits for funding, instead private institutions that were involved in implementation, were funded directly by the BMGF. This goes against the international consensus on making international aid more effective. The Paris Declaration on Aid Effectiveness, was passed in 2005 as a result of these worldwide discussions. Government representatives from both developed and developing countries responsible for promoting development and Heads of multilateral and bilateral development institutions met in Paris and urged for improved alignment of aid with partner nation priorities, structures, and procedures in order to improve the effectiveness of aid initiatives. The Declaration, in particular, committed that donors should disburse aid through existing government mechanisms and to transition from project aid to general budget or sector-wide support, for example through the adoption of sector-wide approaches (OECD, 2005).

There were so many donor partners working in Bihar during 2005-2015 that the government of Bihar felt overwhelmed and wanted better coordinated between the donor agencies. To this end the Gates Foundation was chosen as the lead development partner in Bihar. It formed a State Level RMNCHA Unit (SRU) in Patna subsequently in 2013 (Darmstadt, et al., 2020). The SRU had full-time technical experts from CARE India, communication experts from BBC media action group and technical experts from other development partners. While institutions like the DFID have chosen to fund the Department of Health and the SHSB for their project, BMGF opted for a completely 'government free' funding mechanism. All of its grants were channelled through non-government partners. Over the last several years, there is a growing dependency on development sector funds as well as technical resources, particularly grants from the BMGF in the public health sector in Bihar. Some experts have pointed out that the 'Gates foundation runs its own parallel health system in Bihar' (Respondent 2) Since the beginning of its investments in the health sector in Bihar, Gates foundation has chosen private agencies as grant beneficiaries rather than investing through the states machinery. This is in consonance with the foundation's global strategy, some of its largest grants are given to private intuitions and partnerships, and it is associated with business firms both through its grants and through investments (Sridhar, 2010).

This has had the state government's concurrence all along. However, what it has led to is the active strengthening of the private healthcare sector and fragmentation of the public health system. Many public health workers from lower income countries have often complained that

important health programmes in these countries are being distorted by large grants from the BMGF. Similar opinions were also expressed by one of the respondents in Bihar.

It is also noteworthy that the BMGF, currently the biggest multilateral funder of health projects in Bihar is considered one of the most unaccountable institutions in the world. The management committee of the Gates Foundation oversees all the Foundation's work and is equivalent to the board of directors in any company. The management committee comprises of three co-chairs namely, Bill Gates, Melinda Gates, and William Gates Sr (McCoy, et al., 2009). The imbalance between the foundations global power and its accountability is gaping. In its biggest investment in the state, the Gates foundation completely shunned all government channels and chose only private agencies for implementation of the project as well as disbursal of the entire grant.

One of the criticisms of BMGF and its grant making programs has been that it completely bypasses the local governments (Birn, 2014). The foundation finds it difficult to deal with complex bureaucratic structures and rather choses to rely on a network of non-governmental organizations to implement its programs. If a solid network of such organizations is not present, copious amounts of funds from the foundations stimulates the growth of such organizations.

Lack of information and transparency is pervasive in the grant making process of BMGF, their website provide minimal to no detail on their funding projects. Other than name of the recipient or the program, the amount and year of approval finding any detail on the why and how of funds can be a daunting and often impossible task. Researchers have often called out BMGF for its undemocratic and opaque grant making process (People's Health Movement, 2017). The Gates Foundation has become so rich and powerful; and they have a such wide network of institutions and individuals associated with them, that they have the ability to change the global health landscape through their funding arrangements (McCoy, et al., 2009). Their annual reports are notorious short and reticent; the 2020 annual report was six pages long, although it is a positive change compared to previous years when they simply uploaded major grants on their website in the annual reports section. This is from an organization that spent USD 5.8 billion in grants on healthcare projects in 2020 alone, more than any other organization did in the world. The entire program budget for WHO for 2020-21 was USD 4.8 billion (Annual Reports of WHO and BMGF 2020-21). What the foundation can do to influence health policy in a small and financially dependent state like Bihar is not hard to imagine. A Lancet editorial in 2009 argued that grants given by the BMGF do not reflect the epidemiological priorities of a region, instead they conform to the funding priorities of the foundation. Instead, many public

health workers from low-income countries have often complained that important health programs in these countries are being distorted by large grants from the BMGF (Horton, 2009). Donald McNeil, former head of the WHO Malaria program, warned that the foundations grants, although crucial, could have unintended long-term consequences. Illustrating how the Mr. Gates has continued to follow the same business strategies that he used as the Head of Microsoft, McNeil writes that "emulating his own strategies for cornering the software market, Gates has created a virtual monopoly in the field of public health" (Jr., 2008).

4.7.3 Private- private Partnerships:

A new phenomenon of private-private partnerships is strongly rising in Bihar where funding agencies are completely bypassing government departments and agencies, partnering with non-government institutions instead. Currently the Gates foundation has several such partnerships in the healthcare sector that are ongoing in Bihar. A list of the ongoing partnerships has been presented at the end of this chapter. The information about these partnerships is not available in public domain and the list was shared with me by a respondent working with one of the partner organizations in Bihar. This list even though not exhaustive is pretty indicative of the growing phenomena of private-private partnerships. The preponderance of such partnerships raises important questions regarding the role of philanthropic foundations in strengthening healthcare market at the cost of public healthcare.

In case of Bihar, we see a huge influx of international development funds in the health sector after 2005, almost all of it was targeted towards maternal and child health. Since it was a period of Millennium Development Goals, which also avowed to reduce maternal and child mortality, naturally there already was a focus on this area from the UN agencies like the WHO and the UNICEF. India's own Reproductive and Child health program (RCH) had significantly increased funding in this area through NRHM. On top of it we see a range of programs focussing on maternal and child health in Bihar funded by NIPI, DFID and BMGF.

4.8 Techno-managerial expertise for implementing PPPs in Bihar:

The fact that international aid leads to strengthening and proliferation of the PPPs model has been discussed previously. In Bihar they have followed this strategy as part of the conditionalities for credit disbursals, influencing public policy and choosing private partners for program implementation. In addition to this aid agencies also provide the technical and managerial expertise to the government to enter into long term partnerships with corporations.

Harnessing Non-state actors for better Health for the Poor or HANSHEP is funded by four agencies, namely, the Bill and Melinda Gates Foundation (BMGF), Department for International Development (DFID), the U.S. Agency for International Development (USAID) and the World Bank[19]. HANSHEP 'collects evidence on the adaptation and implementation of health PPPs in low-income countries (LICs) and disseminate this evidence together with success stories and lessons learned amongst health and finance policy makers in the developing world' and this particular PPP came as a result of the one of such evidence gathering and dissemination programs titled 'Pilot Health PPP Advisory Facility'[20]; a four-year program beginning in 2012 that was targeted to;

- Increase private investment in public health systems by 250 million dollars,
- Train senior government officials on implementing PPPs in healthcare
- Publications supporting 'deeper and wider dissemination of evidence on the benefits and critical design elements for health PPPs.'
- Give access to new or improved health services to 1.5 million people

Some of the other programs of HANSHEP include Markets for Health (M4H) Training where they train public officials from low and lower-middle income countries in better handling of the private healthcare sector and improved management of public-private partnerships. 'Advancing Public-Private Dialogue and Healthcare Partnerships in India', introduces initiatives to enhance the interaction between public and private health actors in India. Such initiatives may include online/physical meetings organized between representatives of the government and the private sector and facilitated by HANSHEP.

International Finance Corporation (IFC) is the private sector arm of the World Bank group that acts as an advisor to the Bihar Government on the technicalities of finalizing corporate partnerships. It has been working with the state government and the state's Infrastructure Development Authority (IDA), to 'structure and implement a public-private partnership (PPP) on a project to build, operate, and maintain a greenfield super-specialty hospital in Patna' (IFC, 2016). IFC's work also received financial support HANSHEP.

[19] Taken from HANSHEP website; https://www.hanshep.org/about-us
[20] Available on HANSHEP website at https://www.hanshep.org/our-programmes/pilot-health-ppp-advisory-facility

Conclusion: The case of Bihar reveals an interesting relationship between caste and class dynamics, public institutions and economic development. While the caste-based political mobilizations and movements in the state did lead to a meaningful and politically significant, although partial, empowerment of the lower castes in the state, it also caused a breakdown of public institutions, marginalization of the development agenda and a rise in criminal activities.

The year 2005 is so critical for the political economy of Bihar. There was a change in political leadership which was more amiable to upper caste interests than the previous regime, the conflict with bureaucracy that was a characteristic feature throughout the 1990s was mitigated to a large extent and the lending conditionalities of the World Bank created an environment that was ripe for economic reforms. For the health sector it was even more crucial because the year was also the implementation year for the NRHM. Altogether the neoliberal economic reforms, NPM reforms in the administration, push from donors and the NRHM had created an unprecedented political economic situation in which PPPs became an unequivocal choice. The newly elected government, under pressure to perform looked for immediate and short-term solutions for the structural issues that had weakened the state's public health systems.

A sudden and quantum increase in the money that came from NRHM as well as that from development finance was channelled to achieve quick results through a targeted approach that often ended up being duplicated. PPPs came as a natural choice for the government as it did not have the institutional capacity to utilize the funds. External agencies anyways preferred this route as it offered them more control over the programs funded by them and also enabled them to bypass the complex and often irritatingly slow government machinery. However, none of the stakeholders, whether the state and central governments as well as development finance institutions really thought about strengthening the system for the long run by investing in human resources, infrastructure development, stronger regulations and monitoring and evaluation mechanisms etc. The link between PPPs and privatization of healthcare in Bihar has become even more well-defined after the entry of the Gates Foundation. BMGF's strategy to steer clear of government departments and chose private agencies instead for their program implementation in Bihar is in line with their global strategy. The advent of private-private partnerships in Bihar, led by BMGF's investments has the ability to change state-market dynamics in an already heavily privatized healthcare market.

Table i- Private-private partnerships (BMGF)

Public Health Foundation of India	To design and adopt alternate model(s) for training medical specialists at district hospitals in select Indian states	2016	3.4 million
Asian Development Research Institute	To set up an institute that will generate high quality analytics and evidence on health, and use this evidence to inform policy and health systems design in the state of Bihar	2016	2.2 million
Centre for Catalysing Change	To ensure that government of Bihar makes available quality health care and nutrition services to women and children in all districts of Bihar	2017	1.2 million
Centre for Catalyzing Change	To initiate gender-focused data and evidence building to support gender equality and enhance the impact of government programs and policy for women and girls in Bihar	2017	4.8 million
Centre for Catalysing Change	To support salience of Family Planning in the public and policy discourse and prioritization in Bihar	2018	1.3 million
Asian Development Research Institute	To provide technical support to the Government of Bihar in strengthening selected aspects of the Public Finance Management system.	2018	0.7 million
Innovators In Health (India)	To improve immunization coverage in rural communities in Bihar, India by introducing communal games of snakes and ladders run by health workers in maternity wards and homes of pregnant couples to demonstrate the value of childhood immunization.	2018	
Onion Dev Technologies Private Limited	To facilitate the scaling and sustainability of Mobile Vaani - an IVR based health information sharing and dissemination platform through Jeevika in Bihar	2019	1.2 million
CARE India Solutions for Sustainable Development	To technically support Government of Bihar in strengthening capacity for supportive supervision and performance review and management of their frontline workers	2019	2 million

CARE India Solutions for Sustainable Development	To improve efficiency and effectiveness of collection and use of data under the Government of India’s Integrated Child Development Scheme by scaling up use of a digital platform, Computer Aided Software (CAS) across eight states in India	2019	1.5 million
CARE India Solutions for Sustainable Development	Responsive Technical Support to the government of Bihar to support the public health system in Bihar in addressing outbreaks	2019	0.5 million
Centre for Advocacy and Research	To provide communication support to Uttar Pradesh (UP) and Bihar on Covid-19 response	2020	0.19 million
Asian Development Research Institute	To provide technical support to GOB for effective implementation of PMJAY in Bihar	2020	2.4 million
Centre for Advocacy and Research	To provide communication support for program priorities in Bihar	2021	0.2 million
Piramal Swasthya Management and Research Institute	Diagnostic exercise to study Bihar's health system gaps; co-design sustainable long-term strategy	2021	0.7 million

Chapter V

Partnerships by their nature are expected to be complementary arrangements between two or more parties where they trade-off each other's strengths and weaknesses by joining forces. Ideally both partners are supposed to benefit from this complementary sharing of resources and of risks and rewards. Pro-PPP literature, coming from disparate sources, is bound by this common rudimentary theme that in one way or the other the state and the market complement each other, neutralizing each other's shortcomings with the other's strength. A government has capital but it doesn't have the technical capability to executive a health program, so it enters into a partnership; government neither has capital nor has technical capability, it then provides other capital-intensive resources like labour and financial incentives to a private partner that brings capital, manpower and managerial expertise; so, on and so forth. However, what happens in cases where both the government as well as the markets fail? What kind of PPPs such economies would produce and what are the likelihoods of a partnership being successful when both the constituents are failures in their individual capacities? These are some of the questions that must be asked if one has to look at the history and the contemporary landscape of healthcare PPPs in Bihar, which is a textbook case of a government and a market failure.

PPPs are often looked at in the context of the virtues of either the public or the private sector. Advocates extol the virtues of private while critiques highlight the weaknesses of private. And it is the general proposition that the relationship is complementary, where one partner lags, the other excels. However, Bihar is one place where this framework of looking at PPPs is just inadequate and also is a failure. PPPs in Bihar have to be looked at from the framework of government and market failure in the larger context of neoliberalism. As it has been already argued in Chapter I, Stiglitz argument in support of greater government regulations when there are market failures emanating from inequal dissemination of information and undeveloped markets calls for stronger interventions in a state like Bihar where the private sector is so disparate and unorganized and has a history of engaging in unethical practices towards its goal of profiteering. There is also a more or less consensus among economists, even some neoliberals have started to agree now that markets by themselves are not always capable to address market failures and therefore state intervention in the form of regulations is necessary for economic stability. Former head of American Federal Bank and famous neoliberal

economist, Alan Greenspan, regarded in American political economy circles as an 'economic sage' also conceded that the self-correcting power of free markets are overrated.[21]

There is a large body of public health literature both at the global as well as national level, which has analysed PPPs in healthcare critically and found out that there is a need to exercise caution while considering implementing the partnership model. However, contrary to the evidence we see that partnerships continue to grow and strengthen in the area of public health. While at the global and national level the political economic reasons for this growth are well documented, the same is not true at the state level in India, especially for less developed states like Bihar. At the micro level, the policies are not as well defined as with the macro level, the stakeholders are not as prominent and visible and local issues also determine the way the way partnerships are understood and implemented. Previous chapter attempted to bring out some of the social, political and economic factors that have determined the expansion of PPPs in Bihar. this chapter will investigate how specific PPPs function within the state's health system and what are the challenges typical to Bihar in implementing PPPs? Private sector in Bihar is organized differently than other states, how does it affect the organization of PPPs in Bihar? Key informant interviews have been used to better understand these questions and find some answers for them as the evidence or existing literature is scantly available for PPPs in Bihar.

5.1 Organization of the public healthcare system in Bihar:

Public healthcare system in Bihar consists of health facilities at three levels namely, primary, secondary and tertiary levels. Although a health system is more than the pyramid of publicly owned facilities that deliver personal health services, these facilities are at the core of any well-functioning health system. They become the sites where the system and the beneficiaries commonly interact with each other and their potential to impact health outcomes is huge. Health facilities at the primary level are the primary contact points between the health service providers and the people The primary level of health care includes Sub-Centers (SC), Primary Health Centers (PHC) and Additional PHCs (APHC). Sub-centres primarily act as hubs for outreach services in the state and are expected to cater to a population of five thousand people. PHCs are at the core of the rural health infrastructure and in addition to being the first level contact points for people seeking healthcare, they also help in outreach activities. According to

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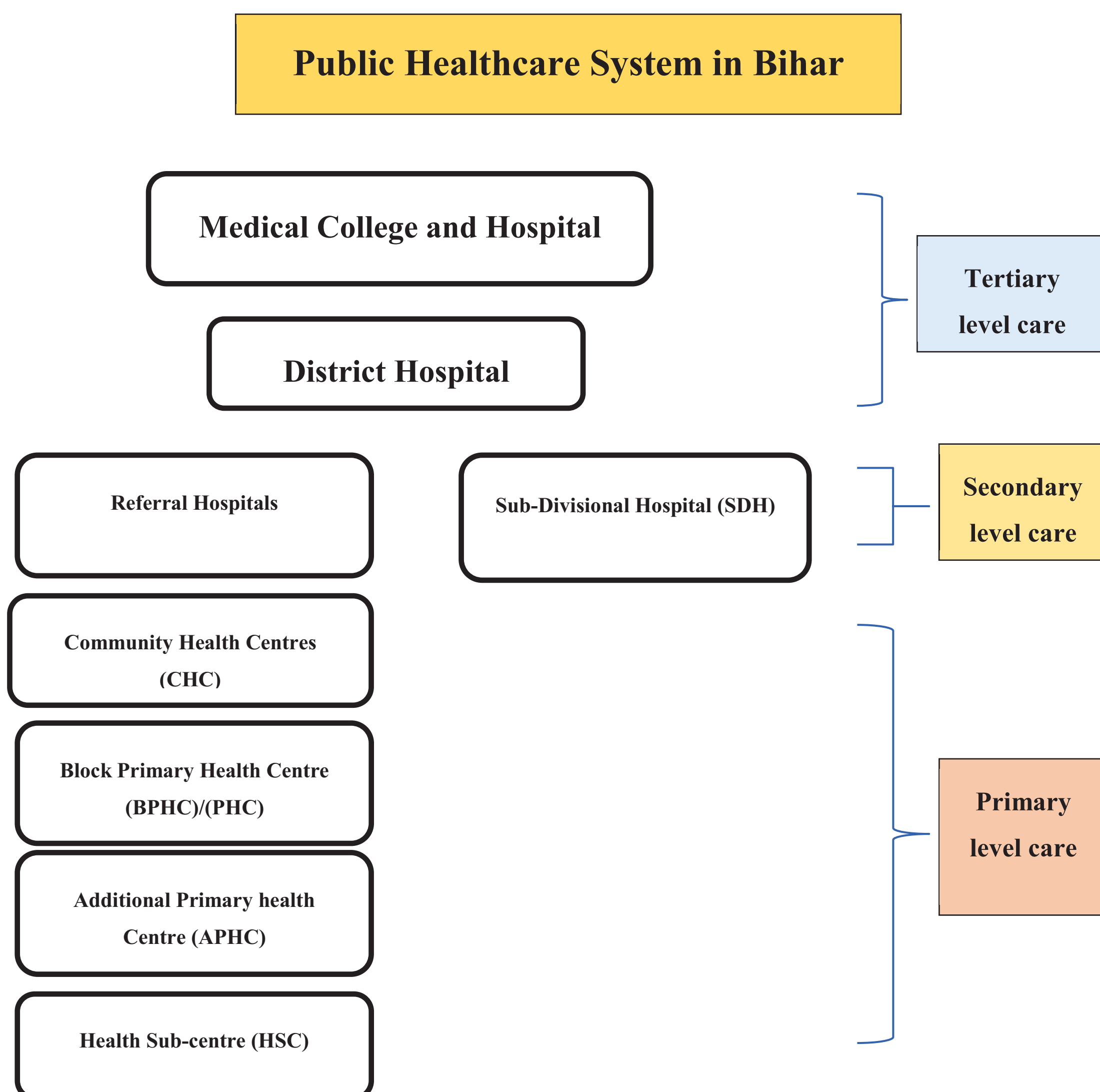
[21] He made these comments during a Congressional hearing of the 2008 mortgage crisis. https://www.nytimes.com/2008/10/24/business/economy/24panel.html

the IPHS norms, there should be at least one PHC for a population of 30 thousand. Health facilities at the secondary level at the first referral units that includes Community Health Centres (CHC), District Hospitals (DH) and Subdivisional Hospitals (SH). CHCs are referral hospitals at the block level expected to cater to the health needs of a population of one lakh. At the top of the healthcare pyramid are the tertiary care health facilities that provide specialized healthcare to patients. The tertiary level of health care also includes medical colleges. Patients generally referred from the primary and the secondary levels are treated at these health facilities.



Population distribution of these health facilities and the availability of health huma resources are determined by the revised population norms in the Indian Public Health Standards (IPHS), ratified by the National Health Mission (NHM).

Table 7: Population and Infrastructure norms for government health facilities- IIPHS		
Type of Health Facility	**IPHS norms**	
Sub-centre (Village level)	1 for 5,000 people.	Staffed by one male multipurpose worker and one female multipurpose worker or an ANM.
PHC (Block level)	1 for 30,000 people.	With 4-6 indoor/observation beds, staffed by a Medical Officer and acts as a referral unit for 6 sub-centres.
CHC (Block level)	Cater to a population of approximately 80,000.	30-bedded hospital providing specialist care. It is the first referral unit for the PHCs falling under its area.
SDH	It caters to about 5-6 lakh people. Depending upon size of a sub-division, a sub-divisional hospital can be 31 to 50 or 51 to 100 bedded.	First Referral Units for PHCs and CHCs in providing emergency obstetrics care and neonatal care. Fills the gap between the block level hospitals and the district hospitals.
DH (District level)	Headed by a Civil Surgeon (CS) cum Chief Medical Officer (CMO). Each district is expected to have a DH linked with the public hospitals/ health centres down below the district such as Sub-district/Sub-divisional hospitals, CHCs, PHCs and SHCs.	Secondary level of healthcare facility that provides curative, preventive and promotive health care services to the people in the district.

Source: (DGHS, 2012)

5.1.1 Health Administration in Bihar

The Ministry of Health and Family Welfare (MoHFW), Government of India is the top-most body in the public health landscape of Bihar. In addition to formulating the National health Policies, it also supports the state in the implementation of various National health programs. Under the National Health Mission, the ministry allocates funds to the states for the implementation of these programs. In several ways, it is the MoHFW, that sets the health priorities for the state being the biggest funder in the health sector. The ministry works with the state's health department to monitor disease outbreaks, advises the department on communicable and non-communicable diseases. Infrastructure and logistical support are provided by the Department of Health for the state's implementation of national health programmes. It is responsible to recruit healthcare workers at public health facilities in the state The Department of Health also plays an important role in coordinating with the state and the district health societies in the state. The Principal Secretary, Health Department, Government of Bihar (GoB), is responsible for management of healthcare systems in the State. Other than the Department of Health, GoB also set up the State Health Society (SHS) in 2005 as mandated by NRHM and Bihar. The State Health Society Bihar (SHSB) is responsible for overall planning, management and implementation of centrally sponsored schemes in the state (Kumar, 2018). The SHSB, like all state health societies is required to prepare an annual programme implementation plan (PIP) and submit to the NHM. The plan outlines strategies, budgetary requirements and expected health outcomes for the state. The NHM has the administrative authority to approve the state's Program Implementation Plans (PIP) and, if necessary, direct the SHS Bihar to make the necessary modifications. The SHS Bihar has the power to decide on medicine purchases, employee hiring, and program oversight (Rupasinghe, 2018). With the MoHFW's approval, it can also make the required adjustments to the administration and execution of national health programmes. The state health society also plays a crucial role in developing public-private partnerships to improve the state's health service delivery. The administration and execution of health programmes at the district level are under the control of the district level health societies. They receive an annual budget and technical support from SHSB for the implementation of these programs.

All establishments under the Department of Health of the Government of Bihar must purchase and distribute their supplies from the Bihar Medical Services & Infrastructure Corporation Limited (BMSICL). The Corporation is also in charge of establishing healthcare facilities and related buildings and infrastructure in the State. It also works in the fields of healthcare services

management and public-private partnerships for the provision of healthcare services. BMSICL was set up in July 2010 with financial assistance from DFID UK (Ibid). Chief Secretary of Bihar is the Chairperson of the SHS, which is expected to serve as additional managerial and technical capacity to Health Department for implementation of National Health Mission. Other members include, Secretaries from NHM related departments such as Health and Family Welfare, Women and Child Development, Public Health Engineering, Water and Sanitation, Rural Development etc., representatives from GOI and Nominated non-official members: Four to six members (Public Health Professionals, MNGO representatives/ representatives of Medical Associations).[22] Construction of healthcare facilities and associated infrastructure/buildings in the State is another task that falls under the purview of BMSICL. At the district level, the Superintendent or Deputy Superintendent is ultimately in charge of a District Hospital, while the Civil Surgeon or the Chief Medical Officer is accountable for the operation of various healthcare facilities within the district.

5.1.2 Private healthcare sector in Bihar:

The private health sector in Bihar is dominated by the upper castes and upper backward castes. The upper backward castes are not well represented in medical practice but due to the wealth accumulation as a result of decades of political patronage, they do have a significant share in the ownership of hospitals/nursing homes. These caste groups benefit from a weak public health system. Nitish Kumar has the support of upper castes as well and upper caste influence is well-entrenched in his government. All the health ministers in his governments since 2005 have been either upper castes or upper OBCs. The upper-class control over private healthcare in the state finds it profitable to keep the public health system weak and dependent upon private markets.

Private or non-government health care facilities in the state can be classified into the following four categories:

- Private health facilities with out-Patient services only; owned by for profit enterprises or individuals. Out-patient clinics run by individual doctors is one of the most frequently utilized service by the people in the state.

[22] https://nhm.gov.in/index1.php?lang=1&level=3&sublinkid=1137&lid=143

- Private health facilities with both in and out-Patient services. Nursing homes owned by doctors are ubiquitous throughout the state.
- Not for profit/ charitable non-government health facilities.
- Pharmacies/ Medical shops (NSSO, 2019).

According to the NSSO report, 65% of health services in Bihar was being provided by a private doctor or a doctor in his private clinic (NSSO, 2019). The national average for health services provided by a private doctor/private clinic in the same report was 43%. Another 11% of the services were provided by the informal healthcare providers against a national average of 3%. There is something unique about the private healthcare providers landscape in Bihar; it overwhelmingly dominated by individual doctors practicing privately or have their own clinics or nursing homes. Only 6% of the patients visited a private hospital for their healthcare needs. Nowhere else in the country the composition of the private healthcare sector is dominated so strongly by private doctors/ clinics/ nursing homes. Average medical expenditure in case of hospitalization was 4.3 times higher in private hospitals than in public hospitals in the state.

There was no legal provision to regulate the private healthcare sector in the state until the year 2013 when the state government notified the Bihar Clinical Establishments (Registration and Regulations) Rules. However, the Indian Medical Association (IMA) boycotted the implementation of the act and filed a legal petition against it, getting an interim relief against any punitive action against non-compliance of the act (Keshri, 2018). According to the National Register for Clinical Establishments, close to 35,000 hospitals have been registered in India as of March 2022 and none of them are from Bihar.

The unregulated proliferation of market has happened along with the withdrawal of the state proving to be a double whammy for patients. It has also resulted in weaning off people from using those services and opting for private healthcare instead. One of the most important determinants of people's health status is their use of health-care facilities that prevent and treat diseases. The usage of health-care facilities, in turn, is determined by access to health-care facilities, which is determined by their availability. People may be unable to access health-care facilities because such facilities are not available, physical access is problematic, or people are financially unable to pay for health-care services. According to NSSO round 60 of 2004, 71% of hospital beds in Bihar were in the public sector, however as the private healthcare expanded and public health facilities stagnated, by 2020 out of the total hospital beds, only 38% remained with the public sector (Kapoor, et al., 2020).

5.2 Financial burden of healthcare on people:

According to NSSO 71st round (2014), ***91.5%*** of the total outpatient visits in the state were to private healthcare providers meaning that less than 10% of the total outpatient services were exclusively provided by a government health facility (NSSO, 2014). In the 75th round of NSSO survey, the figures improved and 18.5% of total outpatient cases were serviced by a government healthcare facility (NSSO, 2019). This still is the highest among all states in India, states like Andhra Pradesh and Haryana where the share of private outpatient visits is closer to Bihar have significantly high insurance coverage vis-à-vis Bihar. That means the financial burden of seeking private healthcare in these states is much lower than in Bihar where only 10.7% of the population had any kind of insurance coverage against a national average of 30% (IIPS, 2022).

Bihar has the lowest per capita income in the country; according to the Economic Survey of 2020-21 it was Rs. 50,555 (GOB, 2021). In addition to the low income, people are forced to bear the cost of healthcare in Bihar from their own earnings. The state has the highest out of pocket expenditure in the country. According to National Health Accounts 2018, 79.9% of the total health expenditure in the state was borne privately by people (NHSRC, 2018, p. 44). This is an extraordinarily large share of OOP expenditure even from global standards. Only two countries in the world have higher OOP expenditure on healthcare than Bihar. For at least 13% of state's people, it led to impoverishment and resulted in financial catastrophe (NHSRC, 2015).

5.2.1 Institutional incapacity, not lack of funds

The reform agenda that the new government in Bihar undertook after 2005 lacked a long-term focus that would have led to strengthening of the state's institutions that were weakened during the previous regime. Aid agencies also focussed solely on the achievement of the immediate goals of the specific programs. Therefore, the capacity of the health system in the state continued to be weak. Although Bihar spends a meagre amount on healthcare, it is rather hard to believe that lack of funding does not seem to be the critical problem in the state. Of course, this does not mean that inadequate funding is not an issue at all or that it has no implications on the condition of the state's public health system. When one considers the fact that the state has not been able to fully utilize the funds allocated by the central government for years now; despite the fact that the amount of allocation is affected by utilization, goes on to point that the lack of capacity of the state public health system is the bigger issue here. The system has been

incapacitated to an extent that it cannot even completely absorb or utilize the money meant for healthcare. From 2005 to 2009, when most of the big-ticket international aid was sanctioned to Bihar, the state could not spend 48% of the funds released under NRHM losing Rs. 552 crores (NRHM, 2010). During the same period the funds released to the state treasury was only 59% of the allocated amount (Ibid). The reduction from allocation to actual release was because of non-utilization of funds in the previous year. If one compares the actual expenditure against the allocated funds then the state let go of Rs. 1353.5 crores in these five years (Ibid).

Bihar is also infamous for not being able to spend a large part of funds provided under the National Rural Health Mission. Bihar government took 191 days in 2017-18 to transfer the fund from state treasury to implementing agency, according to NITI Aayog (NITI Aayog, 2019). This is the highest across all over India. In 2018-19 the Mission Steering Group of National Health Mission decided to increase the Performance based incentive/penalty from 10% to 20% of the NHM budget; this meant that while 80% of the resource envelope earmarked for the State would be assuredly available, 20% of the resource envelope would depend on state's performance on agreed conditionalities (NHSRC, 2019). The States which do not fulfil the criteria could lose up to 20% of funding under NHM. Bihar received the highest quantum of penalty in 2019 of 12%, it was one of the two states who were penalized (Ibid).

As indicated by the state's poor health outcomes in compared to other Indian states, Bihar's health system has had only little success in providing equitable, accessible, and quality health care services to its residents. The insufficiency of Bihar's health-care delivery system in delivering the required services is exacerbated by the state's fiscal and political issues. Uneven access to health care, high inequity, poor quality health care services, insufficient institutional capacity and human resources, and inadequate public health spending associated with high out-of-pocket expenses are all problems plaguing the system. The ratio of private health-care spending to state spending is the second highest in India, and with one-third of Bihar's population living in poverty, the burden of out-of-pocket expenses is devastating for those who are already poor or are very close to the poverty line. Bihar qualifies for enhanced government subsidies as an Empowered Action Group (EAG)1 state, allowing it to improve its poor health results and infrastructure. Unfortunately, increased money has had little impact on Bihar's ranking as one of the worst-performing EAG states.

Chronic neglect of the government health systems has led to significant weakening of these systems in the state. It has not only hindered its ability to deliver good quality health care but

also weakened its core structure to an extent that the state is unable to entirely utilize the funds allocated towards public health. The public health system has over the years lost its capacity to even absorb or utilize the funds towards its own strengthening. Improving the states' ability to absorb funds is a long-term process. It will necessitate long-term efforts to develop management and institutional capacities, as well as the filling of empty positions, higher pay, and increased spending on medications and other consumables (Mukhopadhyay, 2012).

5.3 The case of first Partnership in Bihar

PPP in radiology and pathology services were one of the first partnerships that was implemented in Bihar after the inflow of NRHM funds began and until today these services are being provided at PHCs, CHCs and District Hospitals by private partners at government health facilities. However, these partnerships have embodied some of the worst PPP practices and many of the issues highlighted above can all be found to plague these partnerships. Inappropriate selection of partners, careless documentation, lack of monitoring and evaluation are some of the problems that are dominantly present in these PPPs. The first such partnership was started in 2006 for Radiology (X-ray and ultrasound) and subsequently another partnership for pathological services was also started in the same year to two companies. The objectives of the partnership were to provide cost effective radiological (X-ray) facilities at the government hospitals according to the needs of the local communities, to increase the community's confidence in the public health services and to reduce incidences of health complications due to delays in diagnosis by providing speedier services (PHRN and JSA, 2017). A company from Silvassa named IGEM Medical Services or IGEMS was chosen as the partner. The tenure of the PPP was extended twice to last until 2018 until 2018.

> "The selection of IGEMS for the PPP was itself questionable. A company from the other corner of India with no experience of working in Bihar or no exposure to run a state level medical service was chosen arbitrarily by the SHS." (Respondent 3)

However, as the initial sense of relief that 'anything is better than nothing' gradually subsided, stark drawbacks began to appear in the radiology services provided in the PPP mode. One of the reasons was the 'sub-contracting' strategy adopted by the SHSB in the PPP**. It allowed to private partner to contract out specific services to third party contractors at local levels without any intervention from the first party, i.e., the government.** This meant that the government effectively lost its control over maintaining uniformity in provisioning of quality

of services and at the same time, monitoring and regulation extremely difficult as the sub-contractors were in partnership with the second party or the private partner and not the government. In most case these vendors/sub-contractors were people who were locally influential, powerful and politically connected and were in a position to pressure the local hospital administration towards their own benefits (PHRN and JSA, 2017).

> "Services quality was ok in the first one or two years, but soon it was clear that profiteering was rampant and neither District Health Societies nor the SHSB had any control over the private partner. There were complaints that even BPL patients were being charged money for x-ray and ultrasound and reports were delayed by several days." (Respondent 4)

The PPP to provide radiology services was not renewed at the end of the contract term in 2018 as the private partner refused to obtain compliance certification of the Atomic Energy Regulatory Board (AERB) operational guidelines that was made mandatory by the Executive Director of the SHSB through an order in 2012 along with appointing of doctors by the agency and obtaining PNDT certificate (Patna High Court CWJC No.10605). The private partner argued that since these specifications were not mentioned in its contract agreement and it was not obligated to fulfil them. However, the government's counter was that the agreement mentioned that the private partner had to follow the guidelines issued by the Government of India and compliance to AERB regulations was a GoI guideline, therefore was binding on the private partner. A bitter legal battle ensued that continued until the High Court ruled in favour of the SHSB in 2018.

Another PPP to provide pathology services in all government hospitals across 38 districts of the state along with setting up of 9 ultra-modern diagnostic centres called Regional Diagnostic Centres (RDC) was implemented in 2007 with two separate partners (each given 19 districts). In this case also, the selection of partners, M/S Softline Media Limited (SML) was previously involved in following business activities: Advertising, Printing of advertising material, Market research, public relations activities, Production of commercial messages for radio, television and film (MCA, 1997). The partnership was cancelled by the SHSB in 2011 citing failure to comply with the condition to open RDCs in designated government medical colleges and hospitals in the state. The other partner, M/S Dirghayu Mahavir Diagnostic was to be given the contract of these remaining 19 districts as well provided they prove that do a successful test-run in one selected district of Purnea on 25/04/2011. Meanwhile M/S Softline Media Limited

through a court order on 31/05/2011, got a time period of three months to complete the pending work and subsequently its contract could have been removed. Mahavir diagnostics who had just taken over the operations a month ago was forced to hand over the services to the previous provider and claimed to suffer significant losses as it had made investments in the intervening one-month period. After three months, SML failed to achieve the desired objectives and Mahavir diagnostics approached the SHSB to be re-awarded the contract. On 29/11/11, it was allowed to provide those facilities and run the RDC at Purnia on ad hoc/temporary basis until permanent arrangements were made. Similar orders were also released by other Regional Deputy Directors (RDD) for other districts. However, on 25/03/13 this contract was also cancelled by the SHSB directing Mahavir diagnostics to remove their machineries/equipment from the assigned RDCs. And the **reason given for the cancellation in the office order was a Sanskrit word *Katipay* meaning 'Uncertain'**.[23] The SHSB awarded the contract to Softline Media Limited, the erring company that had on multiple occasions failed to fulfil its contractual commitments[24]. Apparently the SHSB was justifying its erratic actions on a clause in the agreement that mentioned that the contract 'can be terminated at any time, since it was purely provisional.' The opaque and arbitrary nature of the selection of partners led to constant disruption of pathology services in Bihar. The money it cost the government to implement the partnership and then to fight a prolonged legal battle could have been invested in the government's own pathology labs that would have strengthened the public health system in the long run. As a result, the pathology services provided by the government has been suffering from chronic neglect.

5.4 Data from the Field

One striking inconsistency that was observed while conducting the respondent interviews, especially of respondents who have been working in the public health system, was the lack of enthusiasm about PPPs that is otherwise frequently found in in policy documents. Although this indifference was not categorically stated but it was clear from the non-verbal cues and the way respondents referred to private partners, that they did not share the enthusiasm that people at the top of the policy chain wanted to push down. The way people in the health system look at PPPs is contrary to the way it is presented by the policy makers. There is no enthusiasm,

[23] Case details of review petition dated 15-01-2015 I.A. No.7364 of 2014, M/S Dirghayu Mahavir Diagnostic vs The State of Bihar & others on 15 January, 2015.
[24] Case details of Civil Writ Jurisdiction Case No.6984 of 2013 M/S Dirghayu Mahavir Diagnostic vs The State of Bihar & others on 23 July, 2013.

don't believe that they are essentially better then public provisioning, an additional accounting and reporting channel, privatized corruption.

One reason for this apathy could be the narrow understanding among people in the health system of what partnerships are? They seem to limit PPPs to outsourcing or contracting only. When enquired about partnership with the BMGF, both respondents from the SHSB said that the foundation is providing 'technical support' and it cannot be categorized as a public-private partnership. Even private partners bemoan this attitude of the SHS officials and find it hard to develop a long-term relation with the government because of being treated like a contractor.

Monitoring and evaluation of the quality of services provided by a private partner during the tenure of a partnership also came out as a problem area during the interviews. There are no clear guidelines that are put down in the EoI or the partnership agreement about how the progress on the particular project is going to be monitored by the government who is the final oversight authority. Because of this even if the SHS officers find that the work done by the private partner is not up to the expected standards or that the progress is too slow, there are no ways through which it can be resolved with the partner and they have to pass it on to the leadership of the SHS.

There are some prominent themes that emerge from the interviews that have been conducted with health experts, members of the SHS and partners in the healthcare PPPs. The approach of the interactions was to identify the shortcomings in the PPP arrangements in healthcare in Bihar, so that the learnings can be used for future course correction. Wallowing in success stories never leads to improvements anyways, it can only lead to complacency and self-congratulatory attitude. Unfortunately, most of the literature on PPP used by policy institutions doesn't seem to be interested in finding the gaps in these schemes so that they can be improved. Surely, they can't believe that all of them are perfect. Management literature is candid about the learning opportunity that failures can provide. Amy C. Edmondson, Professor at Harvard Business School writes that the 'wisdom of learning from failure is incontrovertible' (Edmondson, 2011). However, it is worth reiterating here that the goal is to not categorise PPPs into successes and failures. In fact, the kind of information that is available around the PPPs in Bihar, such an exercise is technically not even possible. Although there are a few PPPs which have failed so miserably that the government had to prematurely terminate the contracts and a bitter legal battle was fought between the government and the private partners for years. These cases are safe to be considered failures and worth a deeper dive, other than that the goal is to

attempt to find out what are the general shortcomings that have an overarching effect on the PPP scheme in Bihar.

- **Discontinuity of Health Services**

Except for a few small-scale outsourcings of ancillary services, almost every partnership that the government has entered into has ended not to be renewed again. This leads to problems of discontinuity of services in the period when one partnership ends and the next one begins. The process of scoping of a prospective partner through issuing an Expression of Interest, calling of bids and finalizing of bids is a time taking process and often the patients are left in a lurch during this period. The PPP programs in Bihar have not been a sustainable model. Very rarely a partnership has been renewed or extended as it is seldom beneficial for both partners. It is also necessary to be extremely cautious while using PPPs in the context of less developed and predominantly unorganized economies like Bihar. Successful partnerships require the existence of an efficient market and a capable private sector but also of a well-functioning state (Larbi, 1999). This is not always the case in developing countries and specially in economies where both market and government capability are lacking. Bihar is a classic example of such an economy. Even the World Bank advises that PPPs including Contracting out of services and establishing formal accountability mechanisms is not a viable option in states with weak capacity (World Bank, 1997).

The time after a contract expires and before a new contract is signed is a period of desolation both for the health system as well as the beneficiaries. The health system has to scramble to provide even a vestige of the services that were being provided by a private partner earlier and abruptly ended at the end of the contract period. It also highlights that a chronic neglect of health system strengthening and over-reliance on private partners for service provisioning has weakened the system so much that it fails to provide even basic level of care on its own. The case of the diagnostic PPP is a perfect example. As the contract between the SHS Bihar and IGEMS was cancelled abruptly, beneficiaries were left in a lurch. The CAG audit report of 2021 also noted that there were no radiology services in some DHs for over a year (CAG, 2021). District administration was given the mandate to look for service providers locally until a new partner was selected at the state level. This was a problematic decision on so many levels but this was a decision that had to be taken as there were no other alternatives. First the District Health Society lacks the experience of the entire process of scoping, finding and selecting a suitable partner and second many districts did not even have such private entities with the

capacity to provide diagnostic services across the district. Another problem with this approach is the issue of transparency and conflict of interest in the entire process of entering into a partnership. Local partners tend to have more influence on the local administration; in case of an existing partner already providing a service under another agreement, it becomes easier to influence the process to its own benefit. This might lead to selection of partners who don't have the requisite expertise or the capacity to provide certain services. For instance, the company that provided the power back-up/ electric generator services in the public health facilities in the district of Muzaffarpur, ended up landing the contract to provide radiology services, medical supplies as well as the contract for sanitation services.[25] One of the respondents at the district level expressed his exasperation,

> "How can they expect us to do everything that even they (SHS) can't do properly, where is the manpower, where are the resources? Do they think our accountants can prepare a proper MoU? And where will we find suitable service providers? Everything looks rosy sitting in Patna, officers don't know how things work on the ground." (Respondent 2)

In the court case of M/S Dirghayu Mahavir Diagnostic vs The State of Bihar & others, the High court of Patna also pointed out the same criticising the SHSB for acting arbitrarily in cancelling partnership contracts not heeding the adverse impact it would have on public interest.

> "The services that are required to be provided are of emergency nature. On the one hand, the State did not provide the facility and, on the other hand, it has terminated the contract… respondents (SHSB) did not invoke any specific clauses in the agreement for cancelling the agency…The result of the impugned order is that the Government hospitals are without any facilities." (M/S Dirghayu Mahavir Diagnostic vs The State Of Bihar & Ors, 2015, p. 5)

- **Lack of institutional memory**

The failure of public-private partnerships in healthcare in Bihar or for that matter anywhere else as well, to strengthen the health system stems from the same neoliberal ideas that have helped propel it to its now ubiquitous presence. One idea in particular that the argument here refers to is congratualization of workforce; it has been argued in the previous chapter that contractualizaation of workforce has played a significant role in the increase of private profits

[25] Key Informant, District Health Society, Muzaffarpur

as input costs drastically reduces for an employer if the workforce in contractual. Over the years, across sectors, employers, including the state have realized the financial benefits as well as the regulatory freedom that contractual labour provides vis-à-vis regular employment. However, other than higher rates of attrition, one of the significant drawbacks of contractual manpower in the health sector that has repercussions on PPPs was highlighted by an informant from NHSRC as ‘Lack of institutional memory’. As most of the recruitment in the state health society is contractual, there seems to be a loss of “institutional memory” of why the PPPs were formed in the first place. People who work hard to materialize a partnership, they are either moved to other verticals or leave after their contracts expire by the time the partnerships are matured or ending. One of the former employees of an NGO that had a partnership with GOB presented an alternate viewpoint;

> “There is no long-term commitment from the private partner in these PPPs as private partners are treated merely as an outsourcing agency and not partners. It lowers the motivation as well as the involvement from the firm’s side”. (Respondent 6)

- **Selection of Partners not based on quality and credentials but on price quotations**

Selection of private partners is not based on strict eligibility criteria defined by the expertise, credibility or the experience of the company. Often in order to keep the cost low, the bid value is set so low that it makes it easier to apply for newly registered service providers or individuals who can provide low-cost services but reputed players with several years of vintage in the same field find it impossible to meet such a low bid and stay out of the process. However, the quality of the services is affected in order to meet the low-price criteria. It also keeps reputed private partners away from the bidding process as they wouldn’t be able to match the cost set by the SHS. Some of the recent Expression of Interest documents of the SHS still use very broad and loosely defined eligibility criteria while selecting the partners. The EoI documents for the ‘Management of wards in various district hospitals under PPP mode’ is one such example where the eligibility criteria are very loosely defined and kept very open ended. It says that;

> “The Bidder can be a company/ individual/ management companies/ HR agencies with capability of providing the required services along with dedicated staff on their own within the set time lines. The interested party should have an office or capable of opening the same within one month from the date of signing of the contract. Preference

> will be given to service providers who have experience of running the same type of services" (SHS Bihar, 2014, p. 6).

The fact that a bidder can be someone who doesn't even have an office space goes on to show that the SHS Bihar is willing to consider literally anyone for such an important health service. The bar is set so low of the government that they are ready to enter into a partnership with an individual/company to manage the in-patient wards in hospitals, who don't even have an office space. Practically the bid is open to literally anyone who can pay the bid fees and is willing to provide the service.

It was also suggested by a respondent that the presence of a strong private medical lobby also becomes an impediment towards PPP that are patient centric, are designed with clarity of roles and expectations from each partner and have the potential to capture a large section of the patient population that was previously catered to primarily by the private sector. He gave the example of the Oncology Centres that were expected to run on PPP mode in seven Medical Colleges in Bihar subsequent to the release of the release of the EOI document in May 2014.

> "…now you take the example of the cancer PPP, it has been eight years since a good, detailed EOI was released but only one hospital has been set up in Muzaffarpur in 2021" (Respondent 9).

Another respondent from the SHS explained how the process of selecting of partners in a PPP in Bihar is not diligent or rigorous. He said that the selection of private partners is not based on strict eligibility criteria defined by the expertise, credibility or the experience of the company. Often in order to keep the cost low, the bid value is set so low that it makes it easier for newly registered service providers who can provide low-cost services. However, the quality of the services is affected in order to meet the low-price criteria. It also keeps reputed private partners away from the bidding process as they wouldn't be able to match the cost set by the SHS.

The bid to establish cardiology centres within the premises of district hospital also had similar eligibility criteria. According to the EoI document, selection of the partner is simply based on the lowest quotations (SHS, 2014, p. 3). If the lowest quotation becomes the sole criteria to select a bidder, quality of the service provided often suffers as the provider starts to reduce its input costs in terms of fewer number of health manpower, inadequate infrastructure, which eventually leads to deterioration in service quality. Also, as reputable companies/partners with

established creditworthiness in the market often find it hard to match the bids of the local entrepreneurial companies or individual contractors who end up getting the contract.

A distinctive feature of Bihar's large private healthcare market is that it is unorganized not yet as corporatized as it could be. Perhaps that is the reason that on surface it doesn't look like a typical neoliberal healthcare market. According to the 75th round of the NSSO survey, 18.5% of the of the overall outpatient services in the state were provided by a government or a public health facility, this is the second lowest in the country. In the private sector, 64.5% are private doctors or doctors practicing in private clinics; this is the highest percentage of individual practitioners/private clinics in India and equals West Bengal where the share of government hospitals is 28.7%. The selection of qualified partners necessitates an objective assessment of the private health partner's capacity and performance. Basic information on the providers' organisation and management is required for such an assessment. The private health sector in Bihar is a vast and different from the rest of the country. It is hugely unorganized and is dominated by individual medical practitioners and their small clinical establishments/nursing homes. With a huge number of different companies, the market is fragmented. It can be aptly said that it is more entrepreneurial and very rarely corporatized.

- **Lack of due-diligence**

Expression of Interest documents are not drafted diligently so that public interest is protected throughout the tenure of the agreement. Many of them do not adhere to the basic NHM guidelines. Sometimes the contact is only a few pages,[26] leaving a lot of crucial aspects of the partnership out of the legal document, sometimes to the detriment of the government. For instance, in the EoI document for the Management of Wards in Various District Hospital in Bihar under PPP mode, one of the most crucial clauses about the nature of services covered under the PPP, is left ambiguously open.

"The selected partner is expected to manage infrastructure and provide support staff for better functioning of the existing wards. The exact services to be delivered by the selected party will be decided in the later stage" (SHS Bihar, 2014, p. 3).

[26] One of the respondents said that the contract between IGEMS and SHSB was of mere three pages. He did not show a copy to verify this. Neither have I been able to confirm it from any other source.

This kind of language in an EoI document is just mind boggling. In the years that I had spent in the banking industry, I had the chance to go through a few partnerships agreement and contract documents myself but I have never seen documents drafted so carelessly, free from the worry of any future implications that these might bring for the government. The NRHM Task Force for PPPs also recognized the importance of clarity in fixing roles and responsibilities in s systematic and diligent manner for successful partnerships. It states that;

> "The lesson from many of these partnerships is the need for defining obligations of the non-governmental provider as well as the government functionary very clearly. Without a detailed covenant of obligations and liabilities for not fulfilling obligations, it is likely that many such publicly funded partnerships will flounder in the absence of consistent support." (NRHM, 2006, p. 15)

However, there are a few rare exceptions as well that are worth mentioning. An EoI release by the BMSCL in 2014 to Manage Diagnostic Services at Medical Colleges in Bihar is one such case. The detail with which the document was drafted was significantly more meticulous than others. In 2014, government of Bihar had decided to follow a hub and spoke system of diagnostic services across the state in PPP mode and named the program *Anveshan*. Nalanda Medical College and Hospital is the overarching controlling institution and a Centre of Excellence while medical colleges and hospitals in the state are to be developed as hubs that will offer advance diagnostic services. All district hospitals would be developed as spoke, with most common and routine diagnostic facilities. Collection centre facilities for advanced level tests and facilities for most routine and basic diagnostic facilities are proposed at block/PHC/CHC level. Although the PPP is limited to establishment of diagnostic services at NMCH and the medical colleges and hospitals only. Another PPP is envisaged for DHs.

The EoI document has diligently covered the contractual, operational and financial complexities of the partnership, explicitly mentioning several clauses for each so that the scope for misinterpretation and ambiguity is limited. The scope of services, proposed financing model, roles and responsibilities of the private partner as well as BMSCL etc. are some of the broad heads that are mentioned in detail. Very importantly, there is a sub-section on monitoring of the project, which goes into the detail of the monitoring mechanism (the section on quality assurance and monitoring mechanism is spread through two pages). It also mentions that the private partner must submit monthly performance reports to Health Department/BMSICL and

the BMSICL will monitor its performance based on mutually agreed key performance indicators (KPI).

There is a reason that these praiseworthy improvements seem to appear specifically in the bidding documents concerning diagnostic services. Bihar government and its agencies have been embroiled in legal battles with several of their partners in diagnostic services PPPs.

- **Lack of monitoring**

Focus on PPPs in the ninth and tenth fiver year plans, NRHM and RCH I and II programs, National Population Policy 2000, National Health Policy (NHP) 2002 gave a huge boost to the NGO sector in healthcare. All of this was in addition to the preference that external funding agencies have historically shown towards choosing non-governmental partners in their grant making program. The combined effect of all these factors precipitated and led to a previously unseen strengthening of a network of NGO on which a significant part of India's various health programs relied upon. This large-scale NGO-ization of the health sector was particularly severe for states like Bihar who did not have a strong public health system to cope with the post-NRHM influx of resources. However, it also led to some unforeseen and unwanted consequences in Bihar. The dominant sections of the Bihari society quickly realized the huge financial potential of the non-governmental sector. Some of these people with a strong political patronage and allegedly criminal histories also joined the cash-wagon. Many of these NGOs received significant amounts of funds from the government through the RCH programs. The program had no mechanism to detect the criminal ownership of these NGOs or a strong monitoring mechanism to realize that the funds allocated to them are being mis-utilized. It's sort of a common knowledge among people working in the development sector in Bihar that there is a strong political-criminal-business nexus that controls the NGO sector in Bihar.

However, during my field work I came across the name of one particular NGO that seemed like a serious blow to all my preconceived notions. The name of the NGO is 'Sewa Sankalp Evam Vikas Samiti', an organization listed as an FNGO by the MoHFW working in Muzaffarpur district. For some context, it is the same NGO managing a *"balika griha"* or shelter home for young girls where an apparatus of sexual abuse, physical torture and alleged murder was uncovered in 2018. Nearly 36 of the 44 girls living in the shelter home were found to have been sexually abused, many of them raped multiple times. The MNGO associated with 'Sewa Sankalp Evam Vikas Samiti' was 'Mahila Bal Utthan Kendra'. The Director of both

these NGOs, Brajesh Thakur, an influential politician with established links with the husband of then then social welfare minister and alleged links with the chief minister himself is serving a life sentence under the Protection of Children from Sexual Offences (POCSO) Act, and offences of rape and gang rape. Several other members associated with the shelter home were also convicted on various charges, one of whom Kiran Kumari was the director of another FNGO 'Manorma Mahila Sewa Sansthan' under the 'Mahila Bal Utthan Kendra' MNGO.

- **Funders initiate, government has to carry**

After 2005, as the global optimism was building around the Bihar miracle, multilateral organizations and philanthropic foundations also made Bihar one of their major priority regions. A lot of grants from organizations like NIPI, DFID, BMGF along with the World Bank and UNICEF were coming in Bihar. However, all these grants were targeted to specific health needs and had a programmatic approach. Once their tenure was over, the responsibility to continue the program fell on the shoulders of a struggling state government.

> "From the outside programs initiated by the funding agencies seem like a no cost- high benefit option for the state government. But these programs are for a limited time period only and many of those are such that the state cannot abruptly end it. So, it has no option but to bear the expenses alone for years to come" (Respondent 1)

Bihar is one of the five NIPI focus states. The Yashoda program was implemented in partnership with GoB and United Nations Development Programme (UNDP) in 2008. A new cadre of frontline health workers was introduced targeting new-born care in the state. Every newborn in a government health facility in the state is entrusted with one Mamta worker, who is basically a trained midwife and is responsible for ensuring that the newborn is kept warm, is breastfed and receives the first dose of immunization. The worker receives a performance-based incentive for the same. NIPI paid incentives to Mamta workers until 2011 after which incentives have been paid using NRHM funds. A total of 628 MAMTAs were appointed in 48 Hospitals (District and Sub Divisional Hospitals) of Bihar funded by NIPI.[27] However, after

[27] Bihar's A. N. Sinha institute was used as a recruitment and training institute for Mamta workers.

the end of NIPI funding there is no data to indicate that the Government of Bihar has recruited more Mamta workers for the PHCs and CHCs also.

- **Government becomes a dormant partner**

In case of several PPPs in Bihar it is seen that the government ceases to play an active role once the contracts are finalized. There is no monthly/ quarterly reporting by the private agency either to the government or to NHM. This leads to an immediate fall in quality of services and increases unscrupulous practices like it happened in IGEM's case. Although in the new contracts, this issue seems to have been remedied but only nominally. For example, in the *'Management of wards in various district hospitals under PPP mode'* EoI, a clause about monthly reporting by the partnering agency is mentioned, it is not specific about what needs to be reported every month. It doesn't mention any performance-based indicators or anything related to the progress of the scheme. The clause simply mentions that the report should contain "details about all the staff and consumables etc." these types of ambiguous and open-ended clauses can not only lead to problems between the partners as there is no common and concrete understanding on reporting, but it also goes on to show that the lack of due diligence in drafting these documents by the SHS. In the EoI document for setting up of Cardiology centres at multiple DHs in PPP mode, there is **not even a mention** of monitoring or evaluation of services provided by the partner.

In the guidelines issued by the Government of India, it recognizes that public goods and service markets, have naturally monopolistic tendencies, which can lead to exploitation of patients and endangerment of their health and wellbeing. Therefore, ensuring proper regulatory mechanisms while implementing PPPs in public goods and services like healthcare is extremely important. The Draft National Public-private Partnership Policy of the Ministry of Finance clarifies:

> "As provision of many public assets and/or related services has natural monopolistic characteristics, the same would be regulated to ensure that the interests of users and service providers are protected taking into consideration the affordability of the users and certainty of pricing and revenue stream to the private party. ***The regulation would be through independent (multi-sectoral, where applicable) regulators***, ***wherever there is no sector specific regulator, regulation would be through contractual arrangements."*** (MEA, 2011, p. 25)

However, in case of PPPs in Bihar it is evident that these guidelines are not being followed. Neither are there any independent regulators to monitor the functioning of PPPs nor the government ensures that the monitoring clause is essentially included in the EoI or RFP documents. However, considering the variegated nature of the private health sector in Bihar and the presence of the political and the dominant caste-class groups, regulation as a technical and administrative tool only seems to be inadequate. An expert opined;

> "You do a survey of the hospital and nursing home owners in Bihar and you can see they are all powerful people. Even at local levels, most contractors are politically connected; DHS or SHS can't say anything to them. They need support from local administration but everyone wants to keep them happy" (Respondent 3).

- **The inevitability of public-private partnerships**

> "Even though we know the limitations of partnerships and the fact thar partners have no intention incentives to make the public health system more robust and stronger, if we just leave the health system will collapse and whatever limited service, we are helping the government to provide will stop. Who will lose ultimately? It is the patients. Because the state simply lacks the capacity" (Respondent 5).

Partners, and particularly non-profit partners make a thought-provoking point. After all, a patient needs affordable healthcare. Why should he she bothers about who is providing it as long as it fulfils his health needs? "Government is not doing anything. If we are doing something and have been doing it continuously for several years now then why not. Maybe we can set a standard for the government to follow. whatever little is not making things worse for people" This is one question that has no right answers; or at least this research can't provide that. As researchers, observers, commentators it is rather convenient to criticize the motives behind PPPs and their long-term impact.

The case of radiology PPP supports this claim. Despite all the issues that plagued the PPP throughout its tenure, it did improve the radiology services at health facilities as the radiology services available at government health facilities, particularly at PHCs and CHCs, prior to the implementation of the PPP was virtually non-existent.

> "Earlier (before the PPP was implemented) ultrasound facility was available only at District Hospitals and Medical Colleges. Even though X-ray machines were installed

> at CHCs, there were no technicians, or the machines were not working or worst there was no electricity. At least these private companies have generators and technicians who are always there". (Respondent 1)

Availability of radiology services, irrespective of who was providing them, at government health facilities that previously rarely had these services did have a positive effect on the utilization of public health services. Studies have also observed that the lack of radiology services deterred patients from visiting a public health facility in the state. Lack of these facilities was one of the reasons which often deterred patients from utilising the government health facilities (Roy, 2017).

> "Free ultrasound and x-ray services has benefited poor patients, if you go outside you will have to pay up to a thousand rupees for an ultrasound and many rural areas don't even have the facility." (Respondent 9)

- **PPPs don't contribute towards HSS**

None of the respondents claimed that PPPs lead to strengthening of the health system. However, the explanation and the rationale that were offered were quite varied. Health managers commented that partnerships are merely outsourcing of services and therefore it was not right to expect them to contribute towards HSS.

> "I don't think it's a right question. We need a private company to provide some service on our behalf, we float a tender and select a company. Nowhere in the terms of reference document or the partnership agreement it is mentioned that the company should also strengthen the health system" (Respondent 1))

Informants from the partner organizations said that they are already supporting the government at so many levels and across services; they are just not in a position to think from the point of view of strengthening the health system. And that its unfair to have this expectation from them in a state like Bihar.

> "But the point also is; why should we expect a private company or an NGO to strengthen the state's public health system. As the same respondent commented; our team had also gone to Chennai to assist in the COVID related activities during the pandemic. As soon as the cases begun to decline, the people in Chennai said that now they can control

things themselves and asked us to move to Coimbatore to see if they needed assistance. I had never ever heard this from a District health Society or District administration in Bihar; they always want more from us. So, we give them more. There is a need and we fulfil that need." (Respondent 5)

5.5 Two different approaches towards partnership in tertiary care hospitals:

Jai Prabha Medanta Hospital Patna and Homi Bhabha Cancer Hospital & Research Centre (HBCH & RC) Muzaffarpur are two contrasting cases that need to studied to understand how the partnership model facilitated and advocated by international finance institutions open up the health sector for a large corporate hospital. And how there is an alternative to the private market friendly model of partnership that has the potential to provide specialized health services to the people.

The entry of large corporation, hitherto absent in Bihar's healthcare landscape, marks the beginning of a new phase in the neoliberlization of healthcare in Bihar. Private health sector in Bihar is uniquely unorganized and is dominated by individual practitioners and small nursing homes/hospitals (NSSO, 2019). These private players have limited resources compared to large corporations, especially access to capital that includes international capital. This limitation has contributed to healthcare market in Bihar not grow to its full potential, despite having demand for health services and a consumer base who has the ability to pay. Several social, political and economic factors have hindered systematic development of market in Bihar as has been explained previously, however, things seem to be changing now with the entry of one of the largest corporate hospitals in the country. Global Health Patliputra Private Limited (GHPPL) a wholly owned subsidiary company of Medanta Global Health Ltd. entered into a PPP with the Government of Bihar to build a tertiary care hospital in the capital city Patna in 2015. An MOU was signed under which the government agreed to provide 6.6 acres of land to the private partner to build a hospital (MOEF, 2018). The piece of land had an existing hospital and a blood bank named after Jaiprakash Narayan and his wife Prabhavati Devi was called Jai Prabha Hospital and the partnership hospital has been named Jai Prabha Medanta Hospital Patna.

The partnership is based on a Design, Build, Finance, Operate, & Transfer (DBFOT) model for an initial concession/lease period of 33 years. The partnership was facilitated by the

International Finance Corporation (IFC), which acted as an advisor to the Government of Bihar (IFC, 2021).

Average number of outpatients visit in a government hospital per day has been consistently declining in the state over the years. In 2011-12, 330 patients visited a government health facility every day, compared to 308 in 2019-20 (GOB, 2020). The sharpest fall has been registered in the year of the pandemic; only 137 patients visited a government health facility as per the data from 2020-21 (GOB, 2021). Waning of patients from public healthcare facilities is also being recorded in the in-patient category. The inpatient bed occupancy rate in 2010-11 was 58.9 and 55% in 2019-20 (GOB, 2020). A gradual decrease in utilization of both outpatient and inpatient services in government health facilities through the last decade has strengthened the private health provisioning in the state at the cost of the public health system. Beginning of operations by a medical corporate giant like Medanta, supported by the IFC will no doubt benefit a section of the population but it will also weaken the public health system, give the state an excuse not to strengthen infrastructure in public sector hospitals, which will eventually lead to further alienation of patients from these hospitals.

5.5.1 IFC's role in operationalizing the PPP

Although officially IFC was the lead transaction advisor to GOB, considering its extensive and indispensable presence throughout the bidding process it seems that it played the role of an expert technical, legal, analytical, and bidding consultant cum advisor to the government in the bidding. The hospital has been and will be further operationalized in a phased manner, the completion of Phase I of the project required commencement of operation of 100 beds by the end of 2019 and the completion of Phase II required commencement of operation of 300 beds by 2020. Eventually the plan is to expand the hospital to a bed capacity of about 500 beds (IFC, 2021).The outpatient department of the hospital had commenced operation as of November 2021 but the 300 bedded in-patient facility was delayed by at least two years and had not been fully operational by then (Medanta, 2021). One fourth of the total beds in the hospital are earmarked as 'Regulated beds' for which rates are capped at Central Government Health Scheme (CGHS) prices as applicable in Patna. The GoB will have the right to refer BPL patients to these beds, however, it would have to reimburse the cost at government rates to the private developer. Medanta has the flexibility to charge the patients for the remaining beds as per the rates fixed by them. As per the revenue sharing model, Medanta paid an annual

concession fee[28] along with 1% of the annual revenue of the proposed hospital, the concession fee is proposed to increase at a rate of 6.5% every year (IFC, 2021).

Once fully operational, the Jai Prabha Medanta Hospital will be the largest private hospital in Bihar. Currently, Paras hospital in Patna with 350 beds capacity is the largest private hospital.

To question if this new hospital will benefit people of Bihar, the answer is Yes, and not because it is the best possible alternative that the government had among a list of possible policy choices. But because the people of the state are so starved of any of healthcare services that in the present day, any additional health service, even if it is private for profit, seems like a welcome initiative. Private health service in Patna is expensive and exploitative, there are nursing homes which are infamous for overcharging. Middle class believes that at least Medanta will provide good healthcare and it will be more reliable than those other private hospitals. However, there is a clear economic and geographical homogeneity to the people who stand to benefit nothing from this PPP. And those are the poor people living in rural Bihar, especially regions of south Bihar for who access to Patna is still a logistical challenge and access to private healthcare in Patna is a financial catastrophe waiting to happen. PPPs like this are likely to increase the already widening urban-rural health divide in Bihar. NFHS data shows that urban Bihar is already choosing private healthcare over public health facilities and these hospitals will only strengthen the private choices simultaneously weakening the public health system. Unfortunately, the people in rural areas do not have the luxury of just choosing the private healthcare providers over public healthcare as the nature of healthcare market in rural areas is completely different from the urban areas. There are dotted by individual providers who are mostly informal, because hospitals and nursing homes don't find it profitable to operate from a rural area.

Homi Bhabha Cancer Hospital & Research Centre (HBCH & RC) at Muzaffarpur, Bihar is a public-private partnership between Government of India, Government of Bihar and Tata Memorial Centre (TMC). Capital investment towards construction of the health facility has been made both by the Indian as well as the state governments to the tune of Rs. 198.15 crores and 100 crores respectively. The state government has additionally provided land measuring

[28] According to news reports, the concession fees for the first year offered by Medanta was Rs. 3 crores. https://timesofindia.indiatimes.com/city/patna/medanta-bags-bid-to-open-500-bed hospital/articleshow/48103995.cms

15 acres to Department of Atomic Energy (DAE)/Tata Memorial Centre (TMC) in Shri Krishna Medical College, Muzaffarpur, Bihar for the Cancer Hospital (Tata Memorial Centre, 2021). This is planned to be a 100 bedded hospital, which is in still the construction stage further delayed by the pandemic. However, until construction of the hospital is complete, Tata Memorial Centre has commissioned a 50 bedded prefabricated modular hospital on 01.02.2021 in the same premises through Corporate Social Responsibility funds from Alkem laboratories[29] and with donation funding (Ibid). Despite being a modular facility with very limited infrastructure, by the end of 2021, the facility had performed around 120 major surgeries, 400 minor surgeries and 4500 chemotherapies highlighting the desperate need for a cancer hospital in the region, in addition, around 120 new patients are seen in OPD daily (Rajya Sabha, 2021).

Although in strict sense it is a Public-public partnership but it is worth illustrating here for two reasons. One is to explain the ‘Co-location model’ that has been advocated by the NITI Ayog in its Guidelines for Public-private partnerships for non-communicable diseases. The same model is also being used in the state to set up facilities that provide Cardiology services and Catheterization labs at selected government hospitals in the state. Therefore, this kind of model is there to stay, although the partner in all probability might not be another public sector hospital. And two, the involvement of private partners through the CSR (Corporate Social Responsibility) route is a much talked about strategy but its practical examples are hard to come by. Therefore, in some ways, the HBCHRC Muzaffarpur is actually a public-private partnership.

The HBCHRC is a part of the government’s plan have a network of Cancer Hospitals in India on a hub and spoke model. The infrastructure at 29 regional cancer centres across India are proposed to be augmented making them hubs for cancer treatment and approximately 300 government medical colleges should start an oncology department and serve as spokes in the model. The spokes would help in early detection and proper diagnosis of cases and treat patients requiring day care treatments or the limited range of treatments available at these facilities. For more specialized and advanced treatments, these spoke hospitals will connect their patients to the hub hospitals. this arrangement is expected to reduce the overall cost of setting up full-fledged cancer treatment hospitals everywhere by more than 50% (Rajya Sabha, 2021). The Homi Bhabha Cancer Hospital (erstwhile Railway Cancer Hospital) in Varanasi was

[29] Rs. 20 crores have been provided by Alkem laboratories under its CSR initiative.

considered as the successful trial run for this model, which catered to more than 10,000 patients in the first year of its commencement of operation. The refurbishment and augmentation of Dr. Bhubaneswar Borooah Cancer Institute (BBCI) in Guwahati was also done under this plan. Two new cancer hospitals in Sangrur, Punjab and Vishakhapatnam, Andhra Pradesh were also commissioned before operations at Homi Bhabha Cancer Hospital & Research Centre (HBCH & RC) at Muzaffarpur were started (Tata Memorial Centre, 2021).

Cancer has the second highest burden of non-communicable disease in India after Coronary Artery Disease and some estimates suggest that 0.7 million people dies because of it in 2018 (D'Souza, et al., 2013). Even though there are no official estimates on the prevalence of cancer in Bihar, just by the sheer size of its population, it's safe to say that it would be proportionately high. One mathematical estimate suggested that by 2026, there would be 1.3 million new cancer cases in Bihar (Pandey, et al., 2019). Therefore, HBCHRC is a much-needed initiative and the fact that it has not been opened in Patna is also a welcome change.

Conclusion: The argument that PPPs can provide the capital investment in healthcare that resources starved economies simply can't afford to has a very limited evidentiary basis. As is evident from a large number of PPPs in Bihar, that unlike the high-income country model of PPPs that was based on the private financing of a healthcare project, PPPs in less developed settings are primarily used for provisioning of services. Therefore, one of the basic tenets of PPPs that they provide financial succour to cash starved economies fails to apply in Bihar.

Inefficiencies are also created by the difficulty of monitoring and regulating PPPs, particularly where government capability is poor and there are too few private providers to assure price competition. The world bank has also warned that a weak state regulatory system could be a hindrance in a sustainable PPP model, it argues for a clear legal and regulatory framework. Bihar is a classic example of such a weak regulatory state, framework to regulate the private healthcare sector including diagnostics and pharmaceutical are virtually missing in the state. Same is the case with public-private partnerships; an analysis of the EoI documents of many such partnerships clearly shows that even the intent to monitor and regulate is missing at the inception stage only.

The full transaction costs that the government of Bihar incurs in managing a public-private partnership in the state is not computed. Therefore, it is difficult to make an economic argument in favour of PPPs when it comes to cost effectiveness vis-à-vis public provisioning. Also, there

is no evidence at all that health services through the PPP mode are of better quality. In case of a facility-based healthcare PPP, it might look visibly more appealing than a typical public health facility, there is no proof that the quality of the core health service is better in case of a partnership or a private provisioning.

Table ii- Ongoing PPP by Government of Bihar through SHSB and BMSCIL				
MRI services at Hospitals	Design, Build, Finance, Operate and Maintain	4 Medical College and Hospitals	Installation, Operation and Maintenance of MRI Centres in Medical Colleges & Hospitals of Nalanda, Bettiah, Gaya and Muzaffarpur. State government to provide the private partner space within the medical college, which would be redeveloped according to AERB standards by the private partner. Private partner to give a monthly rent to the government hospital All services to be provided at CGHS rates to all patients including private patients. BPL patients to avail free services. The MS of the Medical Colleges & Hospitals has to write 'free' on the OPD card, only then they are to be considered for free of charge service. Tenure of Parentship 10 years. Partner given three years to receive National Accreditation Board for Hospitals & Healthcare Providers (NABH) accreditation.	The private partner can seek an 'on-call arrangement concerned doctors at the medical colleges and hospitals' in case they require additional resources even after employing the minimum number of radiologists and technicians. This clause will deter the private partner from employing additional manpower on their own as they can always borrow them from the hospital in case a need arises. Three years is a very long time to receive NABH accreditation.
24x7 Dialysis service centres government hospitals	Design-build-finance-operate-maintain	38 government hospitals	24x7 Dialysis service centres at two clusters of 19 government hospitals for a period of five years. Supported by the Pradhan Mantri National Dialysis Program to provide dialysis services under NHM in PPP (Public-private Partnership) mode.	According to RoP 2020-21, 140400 haemodialysis sessions should have been conducted in a year. Instead, only 639 (less than 1%) sessions were conducted casting serious aspersions on the utility of these centres.
Establishment and Management of Cardiology Centres at Multiple Location in Bihar under PPP Mode	Co-location model based on "Build-operate-transfer"	12 Hospitals (8 DH and 4 SDH)	To set up Cardiology centres in six District hospitals in the state. Another set of four SDH and two DH were added in the same arrangement taking the total number of health facilities to 12. Interventional cardiology services with cardiac catheterization lab. To build, equip and manage the centres that provides cardiac procedures including OPD, IPD, Diagnosis and Surgery including emergency cases. Initial lease term is for ten years that can be renewed at the end of the agreement.	No clause regarding monitoring of evaluation of services provided by the private partner. Except for one which mandate that the patient records are also to be shared with the government through any of their interfaces like *Sanjeevani*.

Cancer Treatment Centres at Government Hospitals and Medical Colleges in Bihar	Co-location model- Operate and maintain	7 Medical Colleges	A three-tier network of cancer care centres is proposed. At the highest level will be the oncology centre developed at Patna Medical College and Hospital. Regional oncology centres other medical college and hospitals are at the next level providing advanced diagnostics and treatment facilities. At the third level cancer diagnosis and primary care centres will be opened at selected DHs. Infrastructure to be provide by the government, all equipment and support infrastructure shall be provided by the developer. Doctors for overall supervision shall be provided by Govt. of Bihar. However, Doctors for running the cancer diagnostic and treatment facilities should be provided by the private partner. Partnership is proposed to be initially for three years, which may further be extended for two more years on mutual agreement of both parties.	Tenure of the PPP is too short to attract serious partners considering the kind of specialized services that need to be provided and the initial investment in terms of equipments and manpower that is going to be needed to start these facilities. Only one such hospital has been set up in Muzaffarpur till date.
Management Of Wards in Various District Hospitals		All District Hospitals	There are two components of the ward management services: • Setting up of wards- procure new beds, mattress, cupboards, drawers, support staff like ward boys, housekeeping staff, security etc. • Management of Existing Wards- manage infrastructure and provide support staff for better functioning of the existing wards. The tenure will be for a period of three years initially, extendable by another two years on satisfactory performance. The EoI does mention a clause that the 'Service provider will ensure remedial measures with regard to any deficiency in services pointed out by the hospital administration'.	It also talks of a committee appointed by SHSB to monitor the quality and delivery of services. It is the only PPP document which mentions penalty causes in case the service provided is deemed unsatisfactory by the committee. Financial penalty to be imposed in case of 'poor service delivery, dereliction of duty, insufficient staff, rude behaviour and breach of protocol of the wards.'
Development, Operation and Maintenance of CT scan in District Hospitals	Contracting-out	36 District Hospitals	Space within a DH to be provided by the government. Private partner will refurbish the space according to AERB guidelines and do infrastructural repairs wherever needed at their own cost. Other than the space, the government will provide electricity and water supply to the facility. Service to be chargeable at CGHS rates.	No clause on monitoring or evaluation of services. The private partner is practically entering into a partnership with 36 DHs. How equipped are these DHs to manage conflicts/disagreements or

			Head of the DH or an official designated by him will be the overall authority under whom the services will function. The provider will be selected by the SHSB but it will enter into agreement with concerned DHs for each location.	are they even supposed to do it is not clear.
Establishing & operationalizing High-end pathology services on hub and spoke model	Design-build-finance-operate-manage	All medical college and hospitals.	To establish a state wide network of diagnostic centres structured on a hub and spoke model. A Centre of Excellence (CoE) at the highest level located at Nalanda Medical College and Hospital, Patna. Other medical college and hospitals of the state would act as hubs providing advanced diagnostics services. All district hospitals would be developed as spoke, with most common and routine diagnostic facilities. Basic diagnostics facilities at Block/PHC/CHC level along with collection centres for advanced tests. Two different partnerships; one for the CoE and the hubs and another for spokes. Government provides space, building and other basic infrastructural facilities while the private partner provides necessary equipment, consumables, technical and other manpower and for running and maintaining the facilities. Government hospitals to facilitate patient flow to the diagnostic centres. CGHS rates applicable to patients referred by the government hospital, for rest of the patients, the service provider can apply prevailing market charges. Partnership to be initially for three years, can be extended for two more years on mutual agreement of both partners.	Proof of establishment of a complete functioning in-house laboratory to be provided by the partner prior to selection. Supervision and monitoring lie with the government. BMSICL will develop the quality assurance systems for ensuring quality of services. Private partner to abide by these guidelines. In case of dereliction from established criteria, clause for financial penalty or even termination of the partnership is mentioned.
Laundry services at government hospitals	Contracting-in	3 Hospitals in Patna	Government to provide the shell structure with electrical and water supply. Private partner responsible for planning, designing, supplying, installation of machinery, maintenance and operation of laundry services for NMCH, IGIC &PMCH. The agency shall also supply hospital linen. Tenure of Partnership 10 years.	

Table iii- Ongoing PPPs by Government of India		
PPPs under National Programme for Control of Blindness & Visual Impairment (NPCBVI)	Reimbursement for several ophthalmological operations for NGO and private practitioners. Non-recurring grant-in-aid for Vision Centre (NGO). Grants to NGOs for setting up/expanding eye care unit in semi-urban/ rural area	Private hospitals in a rush to claim reimbursements conduct unsafe procedures risking patients' wellbeing. In 2021, a hospital in Muzaffarpur conducted 65 cataract surgeries in a day with three doctors. Negligence during the procedure led to loss of eyesight of 15 of the 65 patients.
National Programme for prevention & Control of Cancer, Diabetes, Cardiovascular Diseases & stroke (NPCDCS)	PPP at State, District and CHC level promoted through the NCD Cell established at the national, state and district levels in order to prevent and control major Non-Communicable Diseases like Cardiovascular diseases, Cancer, Chronic Respiratory Diseases, Diabetes, etc.	
PPPs under the National Viral Hepatitis Control Program (NVHCP)	A national program aimed at the prevention and control of viral hepatitis in India to achieve Sustainable Development Goal (SDG) 3.3 which aims to ending viral hepatitis by 2030. Preventive components include immunization, behavioural change communication, Safety of blood and blood products, injection safety, safe socio-cultural practices, safe drinking water, hygiene and sanitary toilets. PPPs envisaged in diagnosis and treatment component that includes: Screening of pregnant women for HBsAg in areas where institutional deliveries are less than 80% so that both institutional delivery and birth dose Hepatitis B vaccination can be achieved. Engagement with community/peer support to enhance and ensure adherence to treatment and demand generation.	

PPP under RCH program	Processing accreditation/empanelment for private facilities/providers to provide sterilization services. State RCH society has responsibility for the overall management of the scheme. RCH II introduced the Mother NGO (MNGO) scheme, each MNGO works with 3-4 Field NGOs from each district provision of RCH service delivery related to NRHM, Family Planning, Immunization, Mother & Child Health and access to institutional delivery.	RCH program led to huge boom in number of NGOs in Bihar, most of them politically connected and some of them also criminally connected. Some cases of corruption and misuse of funds also reported. Many MNGOs have also been blacklisted by the MoHFW.
PPPs under RNTCP program	The RNTCP program has dedicated guidance documents for PPPs. the first was released in 2014 and the updated version was released in 2019. This document says that there has been 'a fundamental shift in RNTCP's approach to public-private partnerships and 'for-profit' participation needs to be increased. According to the NHM task force on PPPs, 'non-inclusion of the private providers had been one of the main reasons for the failure' of earlier TB control programs. Unlike other state, GoB doesn't provide the data regarding the total number of PPP under the program. West Bengal (179), followed by Rajasthan (90) had the largest number of PPPs according to the last report of 2018.	There is a "Private Sector Engagement Subgroup" under the National Technical Working Group (NTWG) of RNTCP. Members include experts from Faculty of Management Studies (FMS), WHO, BMGF, World Bank, NITI Aayog, NHSRC and USAID.
Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (AB-PMJAY)	Health insurance cover of up to Rs.5 Lakh per family per year for secondary and tertiary healthcare hospitalizations. Beneficiaries identified from the Socio-Economic Caste Census (SECC) of 2011 on the basis of select deprivation and occupational criteria across rural and urban areas. The scheme is implemented through a three-tier model. National Health Authority is the apex body implementing AB-PMJAY, State Health Agencies (SHAs) have been established at the second tier and District Implementation Units (DIUs) are responsible for implementation and coordination on the ground. All public facilities with capability of providing inpatient services (Community Health Centre level and above) are deemed empanelled under AB-PMJAY. Private healthcare providers need to empanel themselves in order to provide care under the scheme, provided they fulfil the criteria according to the 'Empanelment and de-empanelment guidelines' issued by the NHA.	

	The District Empanelment Committee (DEC) is tasked to scrutinize and approve such requests.	
Rashtriya Swasthya Bima Yojana (RSBY)	Launched by Ministry of Labour and Employment targeted towards Below Poverty Line (BPL) families of unorganized sector workers. A cover of Rs. 30,000/- per family per annum. Centre and states's ratio of contribution is 75%: 25%. Beneficiary has to pay Rs. 30 per annum charges.	

Chapter VI

> "Weak health systems are wasteful. They waste money, and dilute the return on investments. They waste money when regulatory systems fail to control the price and quality of medicine… Above all, weak health systems waste lives. Weak health systems are almost certainly the greatest impediment to better health in the world today. They are the central obstacle that blunts the power of global health initiatives" (Chan, 2009)

Public-private partnerships in healthcare have their own strengths. In a state like Bihar, where the public health system is not robust and is unable to fulfil the healthcare needs of a large sections of populations, PPPs are useful in partially filling the gaps between the health system and the people. However, as it is evident in case of Bihar, due to various political economic and as well as social factors, partnerships end up being one of the mainstays of the health system due the state's prolonged reliance on them. How do this prolonged reliance on PPPs affects the state's health system is the key question that this chapter seeks to look into. Evidence from all over the world indicates that a strong health system is essential for improving health outcomes (WHO, 2009). A weak health system becomes an inescapable drawback for all public health programs, hindering their effectiveness. There is a growing consensus among public health scholars as well as international agencies which fund a large number of health programs that interventions in public health should also contribute towards strengthening a health system.

6.1 Key Health Indices in Bihar

One of the simplest measures of a health system's performance over the years is its impact on health outcomes. The impact of a weak public health system is unambiguously visible on the health indicators in the state. Bihar is the second-worst performing state in the NITI Ayog's state index in 2017-18, and its score has fallen since 2015-16 (NITI Aayog, 2019). It was India's weakest state, with an incremental change of negative 6.35 percent. The deterioration between Base Year and Reference Year was primarily attributed to the performance related to total fertility rate, low birth weight, Sex Ratio at Birth, TB treatment success rate, quality accreditation of public health facilities. In the health index report published by the NITI Ayog, Bihar consistently figures amongst the worst states in the country. The state is still struggling to control several neglected tropical diseases. Kala-azar or Visceral Leishmaniasis continues to be a huge challenge for the state, it contributes >61% of the total Indian cases annually, and a few districts of the state have reported more than 600 cases annually (Kumar, et al., 2020).

According to the UNICEF, a newborn dies every eight minutes and an infant dies every five minutes in Bihar. Development indices including that of health are one of the worst not only in India but in the world. An Infant Mortality Rate (IMR) of 47 per 1000 live births is not only the highest in India, it is higher than all our neighbouring countries other than Pakistan. That means of every one hundred new-borns in the state, five die before they become a year old. It is a distressing distinction to hold but sadly it is just one of many; the Neonatal Mortality Rate (NMR) in the state as per the latest round of NFHS data is 34.5 per 1000 live births, the average global rate is 17 (IIPS, 2022). India is the single largest contributor to the global neonatal mortality numbers and Bihar is the worst state in the country. Despite significantly increasing the number of institutional deliveries in the state (76.2%) by providing both supply and demand side incentives, the state continues to have such high neonatal mortality. This points out to the poor quality of obstetric care in the state. Only a quarter of the expecting mothers received the mandatory minimum four antenatal care visits in the state during 2019-20 compared to 14.4% during 2015-16 (NFHS 5). Less than 60% of mothers receive some kind of a postnatal care from a health personnel in the state. Huge shortfall of health personnel including ANMs, nurses and doctors is one of the primary reasons for the lack of postnatal care.

The under- five mortality rate of Bihar is also the highest in the country. As per NFHS 5, it was recorded to be 56.4 per 1000 live births (IIPS, 2022). Not only Bihar is the worst state on the three child mortality indicators, what's worst is the margin with which it lags behind the other states. For instance, the second worst state in terms of the three indicators as per NFHS 5 is Assam with IMR 31.9, NMR 22.5 and U5MR 39.1 (Ibid).

Women are worse off than men on all indicators. More than 63% of the women in age group of 15-49 years in the state are anaemic; the prevalence in men in the same age group is just 30% (IIPS, 2022). Not only this, every health statistic in the state conforms to the fact that the condition of women is significantly worse than men. Their lack of participation in a traditionally productive economic activity has meant that the market economy has amicably partnered with the patriarchal society to exclude half of its people from equitable sharing of resources. It's astonishing that 40% of adult married women in the age group of 18-49 years in the state reported to be victims of domestic violence (Ibid). The number was 43.7% during 2015-16, its just astonishing how a report like NFHS survey is telling every four years that almost every second married woman in the state has endured domestic violence (IIPS, 2017). Someone somewhere in the vast labyrinth of ministries and bureaucrats and welfare institutions

must be choosing to look at this fact and continue to ignore it year after year. That is a testament to the purpose of existence of the society, the state and the health system in the state. Only 25% of mothers in the state received the recommended minimum of four antenatal care visits in the state (IIPS, 2022). That contributes in the state having some of the worst maternal and child mortality indicators in the world. 30% of the children with Acute Respiratory Infection (ARI) still can't access a health facility in the state (Ibid).

A Report of the Special Task Force on Bihar constituted by the erstwhile planning commission was published in 2007. Commenting on the condition of healthcare system in the state the report stated:

> "In Bihar, there are substantial gaps in sub-centers, primary health centers, and a very large gap in community health centers along with shortage of manpower, drugs and equipments necessary for Primary Health Care and woefully inadequate training facilities. Other factors affecting the health status include: very high fertility rate; low level of institutional deliveries and a high level of maternal deaths; very low coverage of full immunization; low level of female literacy; and poor status of family planning programme." (Planning Commission, 2007, p. 1).

6.2 Need for Stronger Health Systems

What makes a robust health system? How do we know that a health system is performing well? How does weak health systems affect the health status of people? These are some questions that health system and policy researchers, governments and multinational agencies have been pondering over for decades now. The answers to these questions are seldom standard and vary as the people asking these questions have very different vantage points of looking at people's health and health systems. There is no uniform collection of best practises that can be put forward as a model for increased performance because health systems are inherently context-specific. However, what doesn't vary is the realization that heath systems are critical in improving people's health. Well-functioning health systems share some key traits. They have procurement and distribution processes in place to ensure that individuals in need receive assistance. They have a sufficient number of health workers with the necessary skills and drive. They also use funding mechanisms that are long-term, inclusive, and equitable. Health-care costs should not push impoverished families even further into poverty (WHO, 2007). Weak health systems are one of the most critical impediments in improving the health status of people

from less developed economies (Remme, et al., 2010). The way health systems are designed, financed and managed affects people's health, lives and livelihoods (WHO, 2000). Therefore, improving health systems has become one of the most important if not the most important goals of key stakeholders in public health. There is a more or less and overarching consensus among all critical players working in the area of public health that a strong health system is sine-qua-non for improving health outcomes.

International aid agency USAID professes that a strong health system is the strongest safeguard underdeveloped economies can have against a disease burden that is shifting rapidly and in unpredictable ways (USAID, 2015).. It is practically not possible to introduce and sustain targeted interventions for such a varying and wide range of health needs, therefore a strong health system that would have a horizontal impact across the diverse health needs is the only sustainable solution. UNICEF has also recognized the importance of stronger health systems; acknowledging that targeted input level interventions have a limited impact and it tends to plateau after some time. Therefore, it is essential to improve or strengthen weak health systems in the pursuit of universal health coverage (UNICEF, 2016). Health system strengthening is also one of the three core strategies of UNICEF's 'Strategy for Health: 2016-2030', a guiding document for the organization in the SDG era (Ibid). In a report titled 'Everybody's Business' that was published in 2007, the WHO almost prophetically stressed that until improvements in the performance of health systems are attained, the world will fail to meet the Millennium Development Goals (WHO, 2007). In a 2015 report the Asia Development Bank accepted that communicable diseases thrive in the face of weak health systems and success can only be achieved by bringing a reduction in health care costs and the creation of more robust and sustainable health systems (Asian Development Bank, 2015). Researchers have also pointed out that weak health systems have hindered the efforts to control several infectious diseases including TB, Malaria and HIV (Atun, et al., 2010), (Sahu, et al., 2020).

Strengthening a health system practically means introducing health interventions that directly or indirectly affect the six internationally accepted health system building blocks or core health system functions, namely, service delivery, human resources for health; health finance; health governance; health information; medical products, vaccines and technologies. A well-performing health system is one that can sustainably achieve health outcomes through continuous improvement of these six inter-related functions (USAID, 2019).

Broadly defining, a health system consists of an interconnected an interdependent set of actors, organizations, resources and people, whose primary aim is to improve health status of people. According to the WHO, 'A Health System consists of all organizations, people and actions whose primary intent is to promote, restore and maintain health' (WHO, 2007, p. 2). It not only includes activities that directly impact people's health but also ones that can impact the determinants of health. Through a mix of public health initiatives and the pyramid of healthcare institutions that provide individual health care by both State and non-State actors, a health system delivers preventative, promotive, curative, and rehabilitative interventions. (WHO, 2010). Ideally the boundaries of a health system should encompass all activities whose primary intention in to improve people's health. These definitions are evidently extremely encompassing making any research on health systems a difficult endeavour. To counter the complexity and enormity of defining health systems, the world health organization in 2005 define health systems as a set of six core components or building blocks.

- Service delivery: This component includes interventions that address how health services are organized and managed, to ensure access, quality, safety and continuity of care across health conditions, across health facilities and over time. Good health services are those which deliver effective, safe, quality personal and non-personal health interventions to those that need them, when and where needed, with minimum waste of resources.
- Health workforce: Human resources are one of the most important components of the six building blocks. They are critical towards having a robust health system that can provide responsive and efficient healthcare to all.
- Health financing: A sound health financing system ensures that people can access the services they need and are safeguarded from financial ruin or impoverishment brought on by having to pay for them.
- Information and evidence: To improve management, leadership, and governance, information, evidence, and research about health and health systems are produced and strategically used.
- Medical products and technologies: To ensure equitable access to necessary medical items and technology with guaranteed quality, safety, efficacy, and cost-effectiveness, as well as to their cost-effective and scientifically sound use.
- Leadership and governance: To preserve the public interest in health, it is important to make sure that strategic policy frameworks are in place and that they are combined with

efficient oversight, coalition building, regulation, attention to problems with health-system architecture, and encouragement of accountability.

While financing and health workforce are key input components of a health system, service delivery and medical products and technology reflect the immediate outputs. Health information system and governance/leadership are two overarching components having a cross-cutting impact. Inevitably, attempts to categorize a complex construct such as the health system is bound to be impaired with issues and gaps. This also holds true for the building blocks framework that overwhelmingly focuses on health sector interventions and either ignores or underplays the importance of actions in other sectors. The framework does not address the underlying social and economic determinants of health, such as gender inequities or education (WHO, 2010). However, focusing on the well-defined blocks helps in encompassing boundaries around the complex and often ambiguous construct that health systems is; and allows researchers to identify interventions that affect the health systems in a more systematic manner. In this chapter three main data sources have been used; NSSO, NFHS, NHA, NITI Aayog reports and the Sate Economic Survey[30], to compare the status of various indicators of the six building blocks

6.3 Have PPPs contributed towards strengthening of health systems?

Weak health systems are almost certainly the greatest impediment to better health in the world today. They are the central obstacle that blunts the power of global health initiatives (Margret Chan). Multilateral institutions have realized that the scope or the ambit of existing public health interventions to reach individuals in most need, in a comprehensive and appropriate manner, is not matched by the ability of health systems to deliver them. (WHO, 2007). One of the most significant barriers to scaling up public health programmes is the failure or inadequacy of health systems. Donor countries have also agreed that strong, resilient, and inclusive health systems are a critical foundation upon which solutions to the world's most challenging health issues depend upon (Foreign Commonwealth and Development Office, 2021). There is an agreement that healthcare interventions should strengthen a country's health system in the long run rather than focussing on achieving short-term targets. Grace Chee and others have differentiated between health system strengthening and health system support as they argue that improper labelling of interventions as health system strengthening discredits them when

[30] The first economic survey was published in Bihar in 2006.

there are unmet expectations (Chee, et al., 2013). They define health systems strengthening as interventions that lead to

> "Comprehensive changes to performance drivers such as policies and regulations, organizational structures, and relationships across the health system to motivate changes in behaviour and/or allow more effective use of resources to improve multiple health services" (Chee, et al., 2013, p. 1).

These interventions being sustainable changes that improve the functioning of the health system instead of just filling the gaps to improve short term outcomes. Interventions that strengthen the health system are beyond providing simply inputs (depth) and apply to more than one building block (breadth) (Witter, et al., 2019).

Keeping this distinction in mind, subsequent sections will look at the temporal change in the performance of the state of Bihar on some of the indicators of the six building blocks of its health system. It must be clarified here that the argument made here is not to establish a causal link between PPPs in healthcare and health systems strengthening but rather the goal is to find answer to the question; whether public-private partnerships, which has been one of the significant public health strategies in the state since the days of the NRHM, has led to health system strengthening? And as evidence from the following section will show, the answer to this question is No. there is no evidence to show that they have contributed towards making the health system in Bihar a stronger, a more resilient health system that is able to produce better health indices for its people. One of the reasons that PPPs don't lead to HSS is that they are, as defined by Chee et al., a health system support strategy. They are by their nature and design short term and specific and are intended to improve service by increasing specific inputs. However, strategies that strengthen the health system are more comprehensive in nature, are systemic, policy level, targeted at macro performance drivers such as organizational structures or work ethics, recruitment, renumeration, undertaking comprehensive surveys etc. This is in no way to say that support activities are not important and only health system strengthening strategies should be undertaken and therefore PPPs are useless. Health system support strategies have their own utility and benefits, they are easier to implement and can be used as a quick fix for an acute problem. Strengthening interventions are often difficult to implement and need a political and organizational motivation.

6.3.1 PPPs and Health System in Bihar

Radiology and Diagnostic services are two areas in which the first PPP were implemented in Bihar. According to the RHS data of 2019, more than 76% of the technician positions at PHCs are vacant in the state. Audit reports by CAG have also reported that machinery and infrastructure at several government health facilities in state including tertiary health centres.

The 6th Common Review Mission of NHM in 2012 made the observation that although the diagnostic services under PPP have increased availability of the services at government hospitals, it has not strengthened the public health system.

> "**Instead of strengthening of Public Health System, outsourcing has resulted into closure of hospital laboratory and X-ray facilities at almost every facility.** Thus, the regular staff (laboratory technician, x-ray technician/ radiographer) has become redundant." (NHM, 2012, p. 15)

The report also noted that the technicians employed by the private agencies to operate the x-ray machines and the laboratory services were not qualified as per the prescribed norms and therefore, the test results from obtained from them were unreliable. The test results were taking longer than the usual turnaround time and beneficiaries were unduly charged for some of the tests that were supposed to be free (NHM, 2012).

The review mission recommended that in order to strengthen the health system, the state must revert back to strengthening its own laboratories.

> "The hospital should operationalise its own laboratories, ***which are practically non-functional now because of existing arrangement for diagnostic services under the PPP mode.*** Out-sourced services should supplement the existing structure and public services, not become its substitute" (emphasis mine) (NHM, 2012, pp. 72, 73)

The 13th Common Review Mission of the NHM also reiterated how the diagnostic services in the state continue to suffer despite relying heavily on the PPP model for the longest time compared to any other PPP. It emphasized on the lack of availability of human resources in diagnostic services in the state, remarking that the '**non-availability of laboratory technicians is a key challenge in expanding the range of diagnostics**' services in the state (NHM, 2019, p. 21). Laboratory technicians are essential for the proper functioning of the diagnostic and

pathology services. According to the RHS data, only 24% of the required number of such technicians are working in the state.

Table 8: laboratory technicians at PHCs in Rural area

Required	In-position	Gap
1899	453	1446 (76%)

Source: Rural Health Statistics data 2019.

An audit report of the district hospitals in Bihar by the CAG was released in 2021 reported that the shortage of lab technicians in the sample checked district hospitals ranged from 58 to 100%, dark room assistant and bio-medical engineer ranged from 60-100%. Patna DH was an exception where surplus radiographer was available (CAG, 2021). The report mentions that the "unavailability of quality laboratory and radiology services may be contributing to delayed or inappropriate responses to disease control and patient management" (CAG, 2021, p. 27) According to IPHS norms, there should be 121 diagnostic tests available at a District Hospital, however, the maximum number of diagnostic tests available at a test-DH in Bihar was only 28 and none of the test-checked DHs were found to have all essential equipment/machines needed for diagnostic services. According to NITI Aayog, a DH in Bihar offers an average number of 8 diagnostic tests, the highest average number of tests in India is 14 (NITI Aayog, 2021).

Other studies have also cast aspersions on the system strengthening capability of PPPs, arguing that PPPs reinforce the targeted approach where health interventions focus on a specific health issue and function in isolation from each other (Nandi, et al., 2021). This stops them from contributing towards making the health system more robust. Even though studies that look at the PPPs from a health system strengthening perspective are a rare few, none of them have supported the claim that PPP strengthen the health system.

It becomes evident from government's own monitoring reports that PPPs have not contributed towards making a stronger health system. Independent researchers, though only a few have also arrived at the same finding from their research studies. The same was also reflected in the expert interviews. If the health system indices in the state also indicate that the PPPs have not had a strengthening impact on the health system in the state, the validity of the claim can be tested through the convergence of data from different source.

6.4 Temporal analysis of change in the health system Building Blocks in Bihar

6.4.1 Building Block1: Health Services

Service provision or delivery is an immediate output of the inputs into the health system. Increased inputs should lead to improved service delivery and enhanced access to services. Ensuring availability of health services that meet a minimum quality standard and securing access to them are key functions of a health system (Murray & Frenk, 2005). According to the WHO, some of the concepts that are used to measure key characteristics of health services are access, availability, utilization and coverage (WHO, 2010). In case of Bihar, NSSO data contains two of the four parameters, which are availability and utilization. Healthcare facilities are the backbone for any strong and sustainable healthcare system. According to the Bihar Economic Survey 2017-18, the state should have more than 4000 PHCs, based on the nationally suggested ratio of one PHC per 30,000 people. However, it only has 533. Even with the APHCs (Additional PHCs), it barely makes it over 2000 (GoB, 2018). According to the Rural Health Statistics data of 2019, there was a shortfall of 39% PHCs, 41% sub-centres and a staggering 81% CHCs in Bihar (MoHFW, 2019). The shortfall is calculated on the basis of the health manpower norms of the Indian Public Health Standards (IPHS). No other state has a bigger shortfall in terms of the number of CHCs than Bihar; the national average shortfall is 30%.

Compared to 2005, the state has noted an increase in the number of PHCs and CHCs in 2018 but the gap continues to be huge. The number of sub-centres has actually reduced in 2018 compared to 2005 as many of them have been upgraded to APHCs (Table 1). The health infrastructure in Bihar has been witnessing in Bihar in the last ten years. Not a single PHC or a referral hospital has been added to the state's public health system after 2009, despite the fact that average population served by a PHC in Bihar was approximately 60% higher than the national average according to RHS 2011 data.

Table 9: Healthcare Facilities in Bihar 2005 vs 2019

Year	PHC	Sub-centre	APHC	CHC	District Hospital	Referral Hospital	Sub-Divisional Hospital
2005	398	8858	1243	101	24	70	23
2019	533	9949	1393	150	37	67	54

Source: [(GoB, 2006) (GoB, 2020)]

According to the 2011 census, population of Bihar was 10.4 crores. In 2012, there were 109 health facilities per million population in the state (MoHFW, 2012). The estimated population of Bihar in 2019 was 12.4 crore and average number of health facilities per million population was 114 (MoHFW, 2019). The proportional increase in number of health facilities from 2005 to 2019 is 4.9% whereas the corresponding rise in population for the same period is 14.2%. To meet the challenge of infrastructural deficiency in healthcare facilities, the state has targeted to upgrade 399 six-bedded PHCs out of the total of 533 to thirty-bedded Community Health Centres (CHC). According to the state's Economic Survey of 2021, 167 such CHCs are operational; considering that 232 such PHC still need to be upgraded, this exercise appears to be an uphill task (GoB, 2021). Out of 70 referral hospitals, 67 have both Outpatient Department (OPD) and Inpatient Department (IPD) facility, whereas the remaining three are having only OPD facility (Ibid).

The condition of functioning health facilities in the state is also found to be wanting. According to the RHS data from 2019, half of the sub-centres don't have regular water supply and 35% of them didn't have electricity (MoHFW, 2019). More than half of the functioning PHCs did not function 24x7, did not have a labour room and the minimum required 4 beds and 77% of them didn't have a referral transport system available with them. Out of the total 150 CHCs, merely 24 (16%) had four specialist doctors working (Ibid).

In terms of utilization of health services, share of public health facilities has increased from 8.25% in 2005-06 to 21.5% in 2019-20 (Table 10). The biggest growth is seen in the utilization of government outpatient services in rural areas. The increase in utilization of public healthcare facilities is greater in rural areas compared to urban areas. However, when we compare the two figures taking NFHS 4 as a midline, it can be seen that the trajectory of growth of utilization of public health services is going down after the initial growth period. Both in urban as well as in rural areas share of public health facilities as sources of healthcare has declined from 2015-16 to 2019-20.

Table 10: Utilization of Public health facilities in Bihar

	NFHS 3		**NFHS 4**		**NFHS 5**	
	Urban	Rural	Urban	Rural	Urban	Rural

Percentage of people using public health facilities as source of healthcare	10.5	6	28.2	21.5	24.6	18.5
Total	**8.25%**		**24.8%**		**21.5%**	

Source: NFHS Reports of Round 3, 4 and 5

An audit of five District Hospitals conducted by the Comptroller and Auditor general of India during 2018-20 found that none of the hospitals had IPD facilities for accidents and trauma. Other types of specialized IPD care such as cardiology, orthopaedics, burn injuries, psychiatry etc were also not available in most of the DHs either due to shortage of human resources or lack of infrastructure of both (CAG, 2021).

6.4.2 Building Block 2: Health Workforce

World Health Organization defines the health workforce as "all people engaged in actions whose primary intent is to enhance health" (WHO, 2010, p. 24). Clinical staff, such as doctors, nurses, pharmacists, and dentists, as well as management and support staff, i.e., those who do not directly provide services but are crucial to the operation of health systems, such as managers, ambulance drivers, and accountants, are included in these human resources (Ibid). The ability of a health system to meet its health goals to a large extent depends on the knowledge, skills, motivation and deployment of the people who are responsible for the organization and delivery of health services. A number of studies have also shown a positive correlation between the number of health workers and better health outcomes (Anand & Bärnighausen, 2007).

More than 70% of the PHCs and APHCs in the state operate without a medical officer or a nurse. According to the Union Health and Family Welfare's Health Management Information System (HMIS) for 2018-19, they were not even considered eligible to be graded for the HMIS. At least one medical officer and one nurse are required for a PHC to be considered eligible for any rating (MoHFW, 2020). In the case of CHCs in Bihar, only 19 per cent got a grade above four in 2017-18 (Ibid). The grading is done on a scale of five with five being given to facilities that fulfil the minimum required criteria on human resources, infrastructure, service availability and utilization, medicine supply, laboratory services and patient orientation in the health facility (NHM, 2017). Only 50% of the sub-centres, 60% the PHCs, and a meagre 9% percent of the CHCs meet the revised IPHS norms population per health facility (MoHFW,

2015). This significant deficit in basic health infrastructure in comparison with other states is one key contextual factor in Bihar. What is incredulous is that the situation seems to be worsening every passing year. For instance, proportion of PHCs working 24x7 declined to 53.8 in the year 2017-18 compared to 73.6 in the year 2015-16 (NITI Aayog, 2019). Considering that there has not been a significant increase in the number of new PHCs in the same time period so that the denominator increased subsequently decreasing the ratio, the deterioration in the quality of the existing public health services is staggering.

Table 11: Number of Doctors: Employed vs Sanctioned 2005 vs 2018

	Sanctioned		Employed		Gap
	Regular	Contractual	Regular	Contractual	
2008	4643	2369	2711	1393	**58%**
2018	7249	4751	2314	533	**76.2%**

Source- Economic Survey of Bihar 2009 and 2019.

Bihar also has a dearth of health-care providers, in addition to its deteriorating infrastructure. The most serious issue confronting the state is a lack of doctors. According to the Bihar Economic Survey 2018-19, the state had a shortage of nearly 76% in the number of doctors working vs the number of posts sanctioned. Bihar has India's lowest doctor-to-patient ratio. In 2017-18, the state had 3679 government doctors (including contractual), which indicates that one government allopathic doctor serves 33,161 people. When one compares it to the WHO's recommendation of at least one doctor per 1000 people, one can see how concerning the situation is. The gap in the required vs available doctors in the state from 2008 to 2018 is a striking statistic that reflects how neglected this critical component of the public healthcare system in the state has been through the decade. It has further widened from 58% in 2008 to 76% in 2018. As population of the state has increased so has the requirement of healthcare; but as the state has failed to strengthen its healthcare system accordingly, people have been forced to seek private healthcare. The neglect of the public healthcare system in the state is one of the key determinants of bolstering of the private health service delivery system and also the increased financial stress of seeking private healthcare. A review of District Hospitals conducted by the NITI Aayog published its report in 2021 and it was found that less than 10% of 36 district hospitals in the state had sufficient number of doctors as per the IPHS norms

(NITI Aayog, 2021). Only three out of the 36 DHs in the state had sufficient number of doctors. Percentage of DHs meeting the staffing criteria in terms of Nurses and paramedical staff was 16.6 and 52.7% (Ibid). Not one of the 36 District hospitals in the state had all 14 of the IPHS recommended diagnostic service facility in the state (Ibid).

Table 12: District Hospitals meeting IPHS norms					
Doctors		Staff Nurses		Paramedical Staff	
Number	Percentage	Number	Percentage	Number	Percentage
3	8.33	6	16.6	19	52.7

Source: NITI Aayog- Best Practices in the Performance of District Hospitals

The health index report, also published by the NITI Aayog highlights the huge shortfall of specialist doctors at district hospitals in Bihar. According to the 2017-18 report there was a shortage of 59.7% specialist doctors at the DHs in the state (NITI Aayog, 2020).

According to the health workforce data published in the 2020 economic survey of the state, Bihar has only half the number of Grade A nurses required according to the population norm of three nurses for every one thousand people (GoB, 2020). It must be noted that there have been significant improvements in the number of working nurses compared to the year 2011. Similarly, despite registering substantial improvements compared to 2011, the shortfall in the number of ANMs required as per IPHS norms is still more than 50%.

Table 13: Number of Grade A Nurses 2008 against 2019					
Grade A Nurses	Sanctioned		Employed		Gap
	Regular	Contractual	Regular	Contractual	
2008	812	3810	464	1005	**58.2%**
2019	14198	4942	10172	422	**55.3%**

Source: Bihar Economic Survey 2007-08 and 2019-2020

The shortfall percentage in the number of ANMs in Bihar is the highest in the country (NITI Aayog, 2019). At the sub-centre level, the shortfall is as high as **59.5%**, human resources are

central to a health system and with such large gaps that have existed for decades in the public health system in Bihar, it has become incapacitated.

Table 14: Number of ANMs working in the state 2008 against 2019					
ANM	Sanctioned		Employed		Gap
	Regular	Contractual	Regular	Contractual	
2008	11251	10946	9720	4564	**35%**
2019	27505	11204	17911	1950	**51.31%**

Source: NITI Aayog Health Index 2019

There is a shortage of ASHAs as well in the state; as per the RHS 2019 data there is a gap of 16.5% in the number of ASHAs currently working in the state against the number of sanctioned positions. The shortfall in the number of laboratory technicians employed at PHCs in rural areas was as high as **76.6%,** shortfall in number of pharmacists at CHCs was **65.3%** and at PHCs was **87.6%.** AN audit report by the CAG, points towards the administrative and managerial lethargy and the lack of willingness in governance and leadership to remedy that lethargy in the recruitment of pharmacists in the state. The recruitment process for 844 pharmacists was started in the year 2015, however, even by the end of 2019, it could not be completed (CAG, 2021).

6.4.3 Building Block 3: Health Financing

Health financing is the area of a health system that deals with raising, accumulating, and allocating funds to meet the individual and group health needs of those enrolled in the system.

> "…the purpose of health financing is to make funding available, as well as to set the right financial incentives to providers, to ensure that all individuals have access to effective public health and personal health care" (WHO, 2000, p. 95).

The goal of health system financing should be to not only raise sufficient funds but to do in such a way that people are not put at the risk of serious financial hardship or impoverishment due to their medical expenditure (WHO, 2010). Indicators in health financing should be able to capture the extent to which people are protected from the financial risks associated with ill

health (Ibid). The catastrophic health expenditure data from the National Health Accounts is an appropriate indicator that can be used to assess the same.

According to the National Health Accounts data, Bihar government spends the lowest amount per capita on health among all Indian states, merely Rs. 425/. The expenditure is significantly lower than the average expenditure by EAG states. Out of pocket expenditure in the state is the highest in the country.

Table 15: Health expenditure in Bihar 2005 and 2015

	Total Health Expenditure (THE)			Government Health Expenditure (GHE)				Out of Pocket Expenditure (OOPE)		
	In Rs. Crore	Per Capita in Rs.	%GSDP	In Rs. Crore	Per Capita In Rs.	% THE	% GSDP	In Rs. Crore	Per capita in Rs.	% THE
2015	24901	2223	6.5	4756	425	19.1	1.2	19890	1776	79.9%
2005	4552	513	4.1	826	93	18.1	1.1	3725	420	81.8%

Source- National Health Accounts 2008 and 2018.

In terms of the health expenditure by the state government on healthcare, it spent 3.9% of its overall expenditure. The national average is 5.34% and the average among the EAG states is 5.05% (MoHFW, 2018). Compared to 2005, there has been an improvement of a meagre 2% in the OOP expenditure in 2018. Government's expenditure on health as a percentage of GSDP has been nearly the same in 2005 as well as in 2018 (NHSRC, 2005).

Because of the state's egregious lack of financial commitment in public health, its citizens are forced to rely on private health facilities, resulting in excessively high out-of-pocket expenses (OOP). It's hardly surprising that, at nearly 80%, its out-of-pocket spending is not only the highest among all Indian states, but also the second highest in the world, just edging out Armenian OOP (which is the highest in the world) by a thin margin (WHO, 2019). As per the NFHS 5 report only 12% of the people in the state have some kind of insurance protection; a marginal decline from 12.3% recorded in the 4th round of the NFHS (IIPS, 2022). Considering

that the per capita income in the state is the lowest in the country; Rs. 31, 380 per annum against the national average of Rs. 1,03, 219 this means the financial burden of healthcare on individuals and households is huge and often of catastrophic proportions (PIB, 2017).

Households reporting catastrophic health expenditure increased from 5% in 2004 to 13% in 2011-12 in the state (NHSRC, 2015). Although data on catastrophic health expenditure is not available after 2011, as per the NSSO report of 2004, loss of income due to medical expenditure was highest in Bihar among all other states. Little has changed in terms of the financial burden of healthcare on people of the state, it continues to be the worst in the country. Households that seek private healthcare, without having a comprehensive health insurance cover, face a huge risk of incurring large medical care expenditures in case of an illness. The significant out-of-pocket costs for medical care caused by this uninsured risk lower welfare and disturb the household's material living standards. This decline in living standards may be deemed catastrophic if the costs of health care are high in comparison to the household's resources. A household's OOPE, which is often higher than 10% of total consumption expenditures, is disastrous and may cause the household to fall below the poverty line, which would result in impoverishment.

Note: The NHA estimates for the year 2018-19 that was released in the middle of September 2022 has shown a drastic decline in the OOP expenditure of India as well as in the state of Bihar. OOPE as a percentage of THE declined from 60.6% in NHA 2015-16 to 48.21% in NHA 2018-19 (NHSRC, 2022). In case of Bihar, it declined from 79.9% to 53.5% (Ibid). The drastic declined has been questioned by several independent experts. In case of Bihar, as per the fifth round of NFHS conducted during 2019-21, a period coinciding with the NHA estimates 80% of the people opted for a private healthcare provider (IIPS, 2022). Utilization of private health services was 81.4% as per the 75th round of NSS survey conducted during 2017-18 (NSSO, 2019). This indicates that the utilization of private health services has remained more or less the same. Another possible explanation could be the that more people are using health insurance of some form to protect them from personal expenditures on health. During 2019-21, 17% households had at least one person with any form of health insurance, during 2015-16 the coverage was 12% (NHSRC, 2022). Almost unchanged utilization of private health services and a marginal increase in the coverage of health insurance doesn’t account for a 26% decline in OOPE in the state. Another possible explanation could be that people are ignoring their hospitalization needs due to the fact that the hospitalization expense is

unaffordable. It seems extremely unlikely that the decline is also caused by increasing number of people who are avoiding hospitalization, as people can postpone hospitalization because of financial hardship but cannot ignore it altogether (Nagarajan, 2022). The debates around the decline in OOPE is still ongoing and until there are unequivocal explanations in the public domain, either from the government or from researchers that the decline captured is real and not a statistical/methodological error, the reliability of these figures will remain questionable.

6.4.4 Building Block 4: Medical Products, vaccines and technologies

Access to affordable, safe and efficacious medicines is a key determinant of good health outcomes; in fact, it is impossible to achieve good health and wellbeing without access to pharmaceutical products (WHO, 2019). It is now widely recognized that a limited category of medicines must be available within the context of functioning health systems at all times. These are called Essential Medicines and the idea was introduced by the World Health Organization for the first time in 1977 (Kar, et al., 2010). A WHO Expert Committee on the Selection of Essential Drugs that compiled the list of essential medicines in 1977 was the result of an active campaign by the former Director General of the WHO, Halfdan T. Mahler, who in his address to the general assembly of 1975 said that;

> "Essential drugs and vaccines are indispensable tools for the attainment of health by all people…If trade in these products is left to depend solely on supply and demand, this can only result in imbalances and inequities. In many developing countries, the lack of national drug policies allows foreign pharmaceutical firms to influence the market demand to a considerable extent…By giving priority to making these essential products available and to promoting the development of better ones, WHO will be instrumental in promoting a dialogue between the governments and the pharmaceutical industry…" (WHO, 1976, p. xiv)

As per the essential Drugs List released by the Department of Health, Government of Bihar in 2018, there are a total of 181 essential drugs listed in the state compared to 376 in the National List of essential Medicines (NLEM) 2015. However, the online drug distribution master of the Bihar Medical Service Corporation Limited, there are less than 75 drugs listed on the item master dashboard. Cost of buying medicines has the biggest contribution in the out-of-pocket expenditure of people and lack of availability of essential medicines at public health facilities contributes significantly to the financial burden of healthcare. An audit by the Comptroller and Auditor General of India found that 59% of the OPD patients in a sample of District Hospitals

in the state couldn't get the medicines that they were prescribed in the hospitals (CAG, 2021). The 13th Common Review Mission report of the National Health Mission notes that;

> "Only limited medicines are available at SHCs-HWCs. For e.g., basic antibiotics, eye and ear drops, analgesics, antihypertensive and anti-diabetic medicines are not available at SHC-HWC." (NHM, 2019, p. 21)

Percentage of fully immunized children in Bihar is the lowest amongst all other states. It's not surprising that a weak primary healthcare system in the state has consistently pulled down the immunization coverage.

Table 16: Immunization coverage Bihar vs India

	Bihar	India
2005	33%	44%
2018	48%	59%

Source: NFHS rounds 3 and 5.

Percentage of fully immunized children in the 0-5 years age group in Bihar was 33% in 2005 against the national average of 44%. Despite registering significant gains as reported in the NSSO 75th round (48.1%), it still remains lower than the national average of 59.2%. Impact of having a weak public health system is also reflected in the child immunization coverage in the state. Public sector health facilities and outreach centres like AWCs are responsible for immunizing close to 90% children in the 0-5 years age group in India.

The ICDS program is designed to work towards improving the nutritional status of children below 6 years of age among other things. It has to do it through a network of Anganwadi centres (AWCs). According to the population norms for AWCs, the state should have 1,52,500 centers for a population of 122 million in 2018. According to NFHS 5, only 52% of children under the age of 6 years received any kind of service from an AWC in the state. The Bihar Economic Survey (2019-20) report the number to be 1,07,603, a shortfall of 30%. AWCs in Bihar are not only fewer than the norm but according to the 2015 ICDS report, several of them don't report their performance to ICDS. AWCs are also severely understaffed in Bihar. The next table presents the vacancy percentage at AWCs in Bihar as reported by the state's Economic Survey 2019-20. ICDS is a primarily service-oriented program and therefore relies heavily on

sufficient staffing. Although the vacancy at AWCs in Bihar has improved in the previous few years, the existing gap is still a critical hindrance in their performance (Table 10).

Table 17- Vacancy at AWCs in 2019-20				
	CDPO*	Lady Supervisor	Worker	Anganwadi Helpers
Vacancy	28.30%	29%	15.10%	18.20%
Vacancy at AWCs in 2005				
	CDPO	Lady Supervisor	Worker	Anganwadi Helpers
Vacancy	66%	85%	1%	1%

Source: Economic Survey 2019-20, Government of Bihar

* Child Development Plan Officer

A Rapid Survey of Children conducted by the Ministry of Women and Child Development (MoWCD) and UNICEF during 2013-14 reported that more than 63% of children aged 6-35 months were not receiving supplementary food from Anganwadis in the state and the figure for pregnant women not receiving the same was astonishingly high at 79% (MoWCD, 2015). Inexplicably the state has continued to not utilize the ICDS funds in its entirety since 2014-15. In 2018-19, 92% of allocated funds were utilized by the states, compared to 96.5% in 2014-15 (GoB, 2020).

6.4.5 Building Block 5: Leadership and Governance

Leadership and Governance in health is increasingly being recognized increasingly as a significant factor on the development agenda. In effect, in building a health system, leadership and governance involves ensuring that strategic policy framework exists and is combined with effective oversight, regulation, attention to system design and accountability (WHO, 2010). According to studies, the most crucial element in these reform initiatives for better health and service access is strong governance. There is proof that measures focused on governance, such as community involvement, monitoring and evaluation, and efficient regulatory procedures, can result in noticeable improvements in health outcomes (Witter, et al., 2019). De-regulation is one of the cardinal principles of the neoliberal ideology. Milton Friedman, arguably the most

celebrated neoliberal economist of all times,[31] even surpassing Hayek himself was well-known for his disdain for regulations or any sort of government oversight (Chernomas & Hudson, 2017). Whether it is the Washington Consensus or the NPM or the Structural Adjustment Reforms; each one of them recognizes regulation as one of the impediments in the smooth functioning of the market, something which is undesirable and should be done away with. Healthcare is not a typical economic commodity, it is public good with inherent concerns about moral hazard, asymmetric information and externalities. Robert Baldwin and others have used a similar line of argument to identify when regulation or government intervention is needed in market. They argue that a government must regulate when there are chances of market failure that could result from any of the following: lack of competition or monopoly, windfall or excessive profits, externalities, information asymmetry, predatory pricing, public goods and moral hazard, unequal bargaining power and planning for future (Cave & Lodge, 2012). All of these conditions apply to healthcare, implying that healthcare is prone to market failure and therefore requires active government regulation. However, in Bihar, regulation of healthcare was never and is still not one of the priorities of the government.

Although the Clinical Establishment (Registration and Regulation) Act was passed by the central government in 2010. Government of Bihar notified the Bihar Clinical Establishments (Registration and Regulations) Rules 2013. The rules are applicable to all types of 'clinical establishments' that includes hospitals, maternity homes, nursing homes, dispensaries, clinics or any institution with whatever name that offers services, facilities requiring diagnosis, treatment or care of illness, injury, deformity, abnormality or pregnancy in any recognized system of medicine established or maintained by any person or a group of persons. According to the Act, a clinical establishment also includes any entity related to providing diagnosis or treatment of diseases where pathological, bacteriological, genetic, radiological, chemical, biological investigations with the aid of laboratory services or any medical equipment. Clearly the Act requires a comprehensive and diverse range of establishments to be registered with the state if they are willing to provide such services. It aims to streamline healthcare services in the country and also to ensure that all healthcare providers, particularly private entities don't engage in unethical medical practices. The law lays down detailed minimum standards of services and infrastructure that a health facility should have to begin and continue its operations. However, in reality apart from large hospitals, there is virtually no regulation that

[31] The Economist called him "the most influential economist of the second half of the 20th century…possibly of all of it". Paul Krugman said that "I regard him as a great economist and a great man"

the large unorganized private healthcare sector in the state adheres to. The huge influence that the private healthcare sector has on the state governments has prevented them from adopting the law that sets strict standards of services. Although a dedicated website has been operationalized for online registration of clinical establishments and providing information related to Act, Bihar is one of the many states that have not provided any details on the platform. It is difficult to compare the quality of care provided by private healthcare providers due to a complete lack of information on inputs, processes, or outcomes in the private health sector. When it comes to clinical quality and healthcare outcomes, we still don't know whether the commercial health sector outperforms the public one (Rajasulochana & Maurya, 2020).

In response to a set of petitions filed before the Patna High court, it was noted that the state doesn’t have a ‘State Council’ under the provisions of the Act. It was also reported that several hospitals that were empanelled under the Ayushman Bharat Scheme were not registered under the Clinical Establishment Act. It was also recorded in detail how the state has not provided in its response any detail pertaining to the grant of registration of hospitals or laboratories.

However, the fact the private health facilities in the state do not bother to register under the Clinical Establishment (Registration and Regulation) Act and continue to operate with impunity is hardly shocking considering the fact that most public health facilities in the state have also failed to do so. In a mixed healthcare system, it has been often seen that the public sector sets the benchmark of quality, ethics and patient welfare and the private sector is forced to follow, otherwise they would lose their business to the public sector. The Department of Health, GOB, issues specific instructions to all CS-cum-CMOs in 2013 and thereafter every year regarding the registration of the healthcare facilities. Although data about the registration of all DHs in the state is not available, a CAG audit of five district hospitals found that four of them had not even applied for the registration and one that had applied and obtained provisional registration didn’t follow through with the process leading to the expiration of the provisional registration (CAG, 2021).

The bizarre cases of medical fraud that happened in Bihar under the Rashtriya Swasthya Beema Yojna (RSBY) - whereby private hospitals could claim up to 30,000 rupees for treating patients who cannot afford expensive procedures refute all the claims that are made to support private healthcare as well as PPPs in healthcare. Private partners not only swindled the state of crores of rupees, they also resorted to unethical, illegal and sometime hazardous medical procedure for the patients. An enquiry report by the Bihar Human Rights Commission found that private

hospitals and nursing homes in Bihar utilised the scheme as a pretext in 2011 and 2012 to perform thousands of hysterectomies even when they were not medically necessary because each surgery guaranteed them a remuneration of at least Rs 10,000 from the government (Rao, 2016). One of the operations was performed on a 14-year-old girl. There were cases of claims approved where hysterectomy was supposedly performed on men; all these health facilities were empanelled with the RSBY (PTI, 2012). A compensation of Rs.2.5 lakhs was awarded to the 702 victims by the state's human rights commission but the state government decided to reduce the amount to Rs. 50,000/ until a High Court order forced them to pay the amount stipulated by the commission in 2019. Reports of fake surgeries or inappropriate surgeries to claim insurance benefits are aplenty in Bihar as well as other states (Gupta, 2016). Only parties not to lose anything in this situation are the private partners; insurance companies and the hospitals. Government ends up shelling out big bucks as insurance premium and in rare cases compensation to the victims.

It is extremely unlikely that governments who are weak at regulating their private healthcare sector or who lack the framework of regulation of the private sector will somehow manage to monitor and regulate them as partners. If anything, their ability to regulate diminishes in cases of partnerships because of the issues of conflict of interest. Some scholars have also warned that there are limits of looking at regulations as a technical and administrative problem, which can be properly addressed in an enabling political environment. However, private health sector often has a complex architecture and there exists contradictions and alliances between its various actors (Baru, 2013). They also exert a lot of influence on the political and the health policy processes at the local, state and the national level. Therefore, any effective regulatory system must engage with these power structures that exist in the private sector and between the private and the public sector (Ibid).

6.4.6 Building Block 6: Health Information System

When reliable and timely information on health determinants, health system performance, and health status is produced, disseminated, used, and analysed, it is said to have a good health information system (Manyazewal, 2017). However, in case of Bihar, health information on all three parameters is consistently absent. A few parameters are covered in some of the national surveys and reports like the NSSO, NFHS, RHS, SRS and CRS, which this chapter has used. However, even for some of these surveys, the state fails to provide inputs from its side. For instance, in the Rural Health Statistics HMIS for 2019-20, the state does not report the number

of sanctioned positions for laboratory technicians and pharmacists at PHCs and CHCs and radiographers at CHCs making it difficult to calculate the shortfall in the number of these positions. The cornerstone of all evidence-based decision-making across all blocks of the health system is accurate and trustworthy information. Policymaking, strategy creation and implementation, governance and regulation, health research, human resource development, health education and training, service delivery, and financing all depend on accurate and up-to-date health information (WHO, 2010).

Correct information on vital events i.e., of births and deaths is necessary not only for the socio-economic planning, but for the evaluation and the effective implementation of various public welfare schemes and programs (James, et al., 2014).

Table 18: Registration of Births and Deaths

	Birth		Death	
	Bihar	India	Bihar	India
2007	16.9%	62.5%	21.7%	55%
2019	89.3%	92.7%	51.6%	92%

Source: (RGI, 2009) (RGI, 2019)

A significant increase has been recorded in the registration of births in the civil registration system in Bihar from 2005 to 2019. This could be explained by the huge amount of focus that the RCH program and within it, institutional deliveries were given. However, registration of deaths continues to be dismal and far below the national average. To improve the process of registration of vital events, the state government had implemented an online process of birth and death registration in 2017, which was started by the RGI in 2015.

WHO also recommends that a robust health system should have a database with public and private sector health facilities and geocoding, available and updated within the past three years and annual data on availability of essential medicines and commodities in public and private health facilities. Considering the overwhelming presence of the private healthcare sector in the state, it is all the more critical that the state has some kind of an information system on the huge private healthcare sector. However, there are none.

Conclusion: Bihar was one of the states to choose the PPP strategy towards achieving its public health goals. Even before the advent of NRHM, Bihar had some of the worst health

indicators in the country and its health system was dilapidated. Although NRHM significantly increased the healthcare funds available to the state, lack of health system capacity and adherence to centre's policy directions meant that PPPs were a natural choice to the state government when it came to healthcare. The state has also been dependent on funding from international development partners and it is known that most development partners prefer the market route when it comes to implementation of their programs. All these factors were in addition to the state's own lack of willingness to become the preferred health provider in the state. However, despite relying heavily on partnerships for close to two decades now, the public health system in the state continues to remain weak and incapacitated. PPPs have been able to contribute towards the improvement of certain health indices but their impact has been short term and compartmentalized. In the long term, a robust health system is absolutely integral to any government's plan to improve population health. In case of Bihar, PPP have given a buffer to the state government so that the public pressure of not being able to provide healthcare to its people does not transfer to electoral plans.

Discussion

Public-private partnerships have become a prominent feature of public health policy and planning globally. Very often they become the preferred model for governments, international finance institutions and multilateral agencies like the WHO and other UN agencies in the health sector. It is expected that such widespread use of PPPs would be backed by evidence that unequivocally prove that they are more cost-effective and more efficient than other available alternatives. However, in reality, either the lack of such evidence or the lack of its robustness is palpable in policy, planning and academic literature. Instead, there is evidence to suggest that PPPs lead to increased marketization of healthcare, weakening of public health systems and benefit private players disproportionately. To find the reasons for the proliferation seemingly unbacked by evidence, this research has unpacked the ideological underpinnings of PPPs and found that PPPs are an important part of the neoliberal ideology that has come to dominate the global political and economic order. The term neoliberalism has come to represent a set of economic theories and policies that advocate individualism, marketization, and privatization of industry, goods, and services, and the financialization of large sections of the economy. It believes that human welfare can be achieved by allowing markets to function independently, away from the interventions by the government

Neoliberalism been the commanding economic ideology of the world for more than four decades now. However, in its formative decades of post-World War II, it remained in the margins side-lined by the Keynesian economic ideas that prevailed during those years. The neoliberal ideology proposes markets as the most rationale and powerful entity in the modern times. It believes that markets are by nature efficient and unbiased; they have the potential to lead to maximum economic growth that in-turn will lead to the betterment of everyone. It also believes that the role of the government is not to undertake or interfere in the economic activities, by doing so it hinders the mechanisms of the free market, making it inefficient. Governments should intervene only to make sure that favourable conditions are created and maintained for the market to develop and strengthen. Ensuring that the there is a spirit of competition in the market is perhaps the most important role of a neoliberal government. Key neoliberal tenets are deregulation, expansion of markets or marketization, and the elimination of government intervention in the market economy.

Health, in a neoliberal framework is like any other economic commodity that is governed by the ruled of demand and supply. Neoliberal healthcare model does not recognize healthcare as

a basic human right of individuals and considers state's interventions to provide healthcare or regulate the health sector as disruptive and undesirable. In case of a mismatch between the demand and supply of healthcare, the neoliberal logic would also prohibit state's intervention as the 'invisible hand' of the market, by its nature, tends to remain in an equilibrium. Neoliberalism presents a value-free, non-normative picture of political economy; one in which the 'free-market' is the ultimate leveller. By relying on keywords such as efficiency and productivity it shrouds economics in a quantitative cover, which gives an impression that economic and economic policies are exercises free from the influence of any value system, ideology or political bias. Economic enquiry is presented as 'scientific' and purely positivist that is independent of any bias. However, this couldn't be farther from the truth; value neutrality is a false pretence. The core values driving the neoliberal free market system is not human welfare, natural justice or equity but it is 'profit'. One of the tools in the neoliberal repertoire during the initial decades was the New Public Management principles. In essence what the NPM approach strives for is to introduce market like behaviours into public services. It restricts the role of the government to being a buyer and a regulator.

Privatization has been a core neoliberal strategy for several decades, until the decade of 2000s when the global financial crisis put the spotlight on private investment banks and their leading role in causing a cascading economic crisis. Increasing economic inequality and the failure of the promise of the trickle down had not only eroded people's optimism in the private sector but it was also threatening to spread and damage the free-market model itself. It is during this time that a rise in academic and policy literature on Public-private partnerships can be observed. Looking at privatization, PPP and the NPM principles in the broader context of neoliberalism and how the three have grown or declined or affected each other, a common theme seems to emerge, which is of 'private good, public bad'. The message to a neoliberal government is to 'privatize if you can, if you can't privatize, learn from the private sector and if you can't learn from the private sector then collaborate with it'.

The World Bank and its subsidiaries have been of phenomenal influence in popularizing the partnership model in the health sector. The pro-partnership approach of the Bank fits perfectly in its ideological commitments. It has been one of the most influential institutions to promote the neoliberal economic model. The Mont Pelerin Society acted as a cradle that nurtured the neoliberal ideology, providing it with a support system that spread across a range of influential individuals and institutions. On the other hand, the World Bank Group ensured that these

policies were disseminated and adopted by countries across the globe. The financial crisis of 2008 forced a considerable change in the Bank's approach towards implementing pro-free market policies in its debtor countries. Perceiving a popular resentment against the privatization policies that it had espoused until the financial crisis, the Bank brought in a change in its rhetoric from complete privatization to cooperation or partnership with the private sector. However, it's interesting to note that the rationale for choosing the partnership model remained more or less the same as it was for the privatization model. Greater efficiency of a private enterprise, its ability to understand people's needs better and the belief that market forces have the ability to solve complex social problems such as those in the public health sector. In one of its reports, it goes on to the extent of using the 'trickle-down' effect to justify the increased use of PPPs.

Structural adjustment programmes backed by the IMF and the World Bank in response to crises offered both the background and the demand for reform in public sector management in most developing nations. Adopting the tenets of the NPM ideology was a part of the conditionalities and therefore the Bretton woods institutions can be credited with pushing and spreading these principles in the Indian economy from the beginning of the 1990s. Multilateral institutions used the conditional lending as a tool to persuade crisis states to implement pro-market and pro-private-sector reforms. 'Cost-effectiveness' and 'efficiency' were the operative words in many of the key policy documents of the world bank and IMF during these times, whereas strengthening of the health system doesn't not come up even once in these documents. The commitment to efficiency and growth was restricted to reducing public deficits and reorienting the economy toward a "minimal state" model by reducing public sector size, expense, and responsibility. According to NPM arguments, backed by the neoliberal ideology, causes of the economic crisis were located in governments' direct interventions in the economy and the lack of performance of the state-owned enterprises. The impact on health planning and policy was immediate and critical, they started becoming a sum total of the cost-benefit analyses of several programs rather than an instrument to achieve health for all.

Even though the term 'Partnership' is widely used to express some form of a collaboration between entities, there is hardly any agreement on 'how to define a partnership'. Despite the scale and significance of the phenomenon, there is relatively limited conceptualization and in-depth empirical investigation. There is a lack of consensus as well as clarity on what constitutes a PPP. Policy documents, reports by multilateral organizations and individual scholars have

defined PPPs with significant variations. Definitions vary from as simple as any kind of collaboration between the public sector with the private to more nuanced ones that include risk sharing, common goals, mutual benefits and long-term tenures. WHO's own definition seems simplistic and broad, according to them PPPs bring together a group of players with the common goal of enhancing a population's health through mutually accepted roles and principles. The conceptual ambiguity has a negative effect on the PPP idea itself. When all arrangements between a private entity with the public are classified as PPPs, their successes or failures become the success and failures of PPPs. Some crucial questions remain unanswered in the PPP discussions; the question of accountability is one, the conflict of the dual roles that the public sector has to play of a partner/buyer as well as a regulator is another.

Partnerships with the health sector in India goes back as far as the pre-independence era. The Rockefeller and the Ford Foundations were the first to support British India in controlling communicable diseases, population control and health education. Post-independence, partnerships with the private not-for profit sector was a major part of the country's health planning. Through the five-year plans systems were put in place that recognized and utilized the expertise and reach of such organizations. Representatives of the sector were made nominated members of the planning commission during the early 1980s. The private for-profit sector also became a major partner of the government in the post structural adjustment era in India. Encouraging and supporting more private tertiary healthcare facilities, contracting in and out of clinical as well as non-clinical support services were recommended by the five-year plans during the 1990s. National health Policy documents from 1983 onwards have discussed the presence of a large private sector and the ways that the government can utilize them better. They welcomed increased participation of the private sector in primary, secondary as well as tertiary care services if the sector was willing to meet the minimum quality standards defined by the government.

However, like the dissemination of neoliberal policies and the pro-market approach in the health sector, the expansion of the PPP model varied from one state to another influenced by the political, social and economic scenario in those states. The private market ecosystem in Bihar, including private healthcare has not been able to grow and develop as much as other higher income states in country. Several factors have led to this underdeveloped market system. The Freight Equalization Policy took away the incentive for heavy industries in the post-independence era to invest in Bihar. Bifurcation of the state in the year 2000 almost completely

took away the rich mineral resources that the state had. It was left with an economy that was hugely dependent on agriculture and its allied activities. However, the agricultural production system in the state was deeply discriminatory and extremely unproductive due to the concentration of cultivable land in the hands of upper castes. With the change in political leadership in 1990, the process of empowerment of the backward castes began in Bihar. However, the material aspects of this empowerment in terms of transfer of land, use of state's resources like agricultural credits etc. were limited to a few ruling middle caste groups. For a considerable period, the conflict between the traditional upper caste and upper classes with the newly rising upper class from the backward castes, created an atmosphere of conflict and this conflict between the new upper class with the traditional adversely affected the development of markets as well as state's institutions.

The year of 2005 is an extremely critical milestone in the history of Bihar, more so for the health sector in the state. Several important changes occurred around this time that proved to be fortuitous for the introduction of neoliberal economic reforms in the state and also for the beginning of widespread implementation of public-private partnerships in the health sector in Bihar. A new coalition government brought the upper caste interests back into the political leadership of the state, which had a particularly encouraging impact on the bureaucracy vs political strife that had weakened the state institutions and was not inclined to create conditions for the growth and development of markets. Bihar's economy that was growing at a rate much lower than the growth of the Indian economy for the reasons discussed earlier underwent major restructuring by the new government. A number of economic reforms introducing more fiscal discipline along with the reduction in government's expenditure were brought in by the new government. However, the real origin of these reforms lied in the conditionalities imposed by the World Bank with a major lending in 2005. The First Bihar Development Policy Loan/Credit was a Rs. 945 crores financial assistance with a 35-year maturity period that was conditional to reforms in four core areas, namely, Fiscal and Public Finance Management reforms, Governance and Administrative reforms, Investment Climate reforms and Social sector reforms. The pressure to reduce budget deficits stopped the state government from increasing expenditure on health. Although it can't be said for certain that the government would have been willing to increase it had it not been prohibited by the lending conditions.

The introduction of the NRHM was another factor that centralized several health programs that were being implemented by the GOI. The consolidation of all programs also increased the

inflow of funds to the states. A state like Bihar, which had been institutionally incapacitated to a large extent was not in a position to use these funds fully. Partnerships with the state's underdeveloped and largely unorganized private health sector was a convenient option.

NRHM played a pivotal role in institutionalizing the PPP model in India. Being a country-wide umbrella program that had in its ambit all vertical health programs, it was uniquely placed to influence the public health landscape in the country. Making promotion of PPPs as one of its strategies to achieve the goals and advocating a minimum of 5% outlay towards them ensured that the private sector, particularly the NGOs received unprecedented state patronage. The idea that the even with limited involvement, governments can achieve the desired public health goals were deeply ingrained. That eased the case for larger participation of the for-profit private sector as well. For the low-income states like Bihar, which were heavily dependent on central funding and had a weak public health infrastructure, partnerships presented a convenient alternative to spend the increased inflow of funds.

The impact of PPPs on the health system in Bihar has not been favourable in a period of close to two decades, as far as strengthening of the health system is concerned. The state has used these measures to look for ad-hoc solutions to health problems that have existed chronically due to the fact that systemic issues have not been addressed. Although the state has been able to fulfil some of the immediate public health needs of the people, it has channelled the limited resources it has away from interventions that would have health system wide positive effects. This has also reinforced an already strong public perception against services that are provided by public institutions. People believe that the state simply lacks the capacity to improve their health status. Privately provisioned healthcare that maintains a looming dominance over the health sector in the state is vindicated as being more efficient than its public counterpart. Private health sector also benefits financially from these arrangements as a captive 'consumer base' is channelled towards them by the government. PPPs in diagnostic services illustrate these factors clearly. In spite of providing these services through the partnership model for well over fifteen years, diagnostics continue to be an area of huge concern for the public health system. Evaluation reports of the NHM and CAG have been unequivocal in saying that there are huge gaps in the diagnostic services in the state; the quality of services that are being offered also have large inefficiencies. They have found that the process of handling over a diagnostic report to the patient takes longer than the stipulated time, patient sometimes have to pay for services

that are free in some cases these services remain inaccessible for many. A few independent research studies have also iterated the same.

Of a few previous studies that have studies the health system strengthening capacity of PPPs, they have limited themselves on specific intervention/s and evaluated the change in a specific service that was being provided by the partnerships. However, in this research the goal was to look at the impact of such partnerships in toto, as one group of interventions on the overall health systems. Specific interventions in the health have the capacity to have an overarching impact on the entire health system. For instance, a PPP in diagnostics is specifically for diagnostic services but it affects several other components of the health systems. Outsourcing of diagnostic services removes the state's incentive to hire more technicians or modernize its own facilities as they are able to procure these services from a private agency.

In terms of the public health facilities in the state, there is a shortfall in the number of facilities required as per the IPHS norms and their availability. While the population of the state has increased by more than 14% from 2005 to 2019, overall number of public health facilities has increased by nearly 5%. Many of them continue to lack basic facilities like water and electricity, more than half of the PHCs don't fulfil the required criteria of at least 4 beds and having a labour room. Utilization of the public health services witnessed a significant increase immediately after the implementation of the NRHM but after the initial increase it has started to decrease. The gap between the required number of doctors and ANMs has increased in the state from 2008 to 2019, while for Grade A nurses it has reduced marginally. Immunization coverage has increased significantly although it remains well below the national average. Availability of essential medicines at public health facilities continues to remain a big challenge. Considering the fact medicines are the single biggest contributors towards OOPE, unavailability of medicines is a huge weakness of the health system in the state. OOPE had decreased marginally from 82% to 80% till 2015. However, NHA estimates for the year 2018-19 that was released in the middle of September 2022 has shown a drastic decline in the OOP expenditure in the state bringing it down to 53.5% that is lower than the national average. However, the fact the utilization of public health services has not increased by much, insurance coverage has increased from 12% to 17%, makes it difficult to find the cause of this drastic decline in private health expenditure. Lack of any government regulation of the private sector is a major area of concern in Bihar. Over the years, several instances of medical malpractices like performing unnecessary procedures to claim insurance benefits, financial exploitation of

patients have been reported from the state. This has not resulted in the formation of a strong and effective regulatory system for the private sector in the state. Opening a private health facility in the state is akin to opening any other business. Other than a few licenses, there is a gross failure in the state to abide by the Clinical Establishment Act. Overall, with whatever limited data is available, it was found that most indicators of the six-health system building blocks in Bihar have not improved drastically from the time when PPPs became a mainstay of the state's health policy, planning and implementation.

PPPs have also consistently utilized a part of the state's public health budget, which could otherwise have been invested in strengthening the health system in the state. From the data analysed in this chapter, it is clear that the utilization of public services has increased in Bihar in both in-patient as well as outpatient categories from 2008 to 2019. The factors responsible for the increase have to be investigated; intuitively one can say that more people are going to public health facilities as public health infrastructure has improved or that the public health system has becoming stronger. However, all other major indicators point out that in all probability that is not a correct correlation to be made. Number of health facilities has not increased proportionally to the increase in population, gap in the number of healthcare providers employed vs required has worsened, out of pocket expenditure has remained almost the same while catastrophic health expenditure has increased. Protecting citizens against the financial hardship induced by seeking medical care is one of the purposes of a robust health system. The increase in utilization of public health facilities can possibly be attributed to the increased cost of treatment in the private health sector. Immunization coverage has increased but it remains significantly lower than the national average, medicines continue to remain unavailable at public health facilities and other than the ratification of the Clinical Establishment Act on paper, nothing has changed in terms of regulating the health sector. Overall, this research has found that public-private partnerships in healthcare in Bihar has not contributed to health system strengthening.

This research also found that the optimism regarding the role of PPPs, which exists among decision makers and influencers at the top is not shared by people who work in the health system in the state. Some of the drawbacks of opting for a PPP at the state level that were iterated by the respondents include the discontinuity in services during the period of end of a partnership and beginning of a new one. In case the previous partnership is not renewed, it is generally left to the managers at the district level to ensure an ad-hoc system for the intervening

period. It was also found that in cases where the PPPs are not long term, there is no institutional memory amongst the people who are involved in the implementation of the partnerships. Frequent change of partners and contractualizaation of workforces in the SHS are major contributors to this problem. Lack of state's own capacity as well as the presence of a private market that is still in the growing phase and is loosely spread also affects the PPP landscape in the state proving to be a significant obstacle in developing partnerships that are mutually beneficial to both partners and are also able to meet the desired outcomes. The popular assumption that partnerships are mechanisms though which the strengths of the public sector is combined with the strengths of the private sector to achieve goals that neither of them can individually meet is challenged in the context of Bihar. In this context both the public as well as the private sector have inherent inefficiencies that compounds when they work together. For instance, the issue of lack of monitoring and evaluation capacity in the public sector and the lack regulations for the private sector led to similar problems in partnerships as well. Most partnerships do not have a system to assess how they are functioning and also lack the mechanisms to allow corrective measures during the tenure of the partnerships. The impact is also visible on how a private partner is selected; in many cases the eligibility criteria is kept minimal, which allows enterprises with almost no expertise or experience in the health sector to become eligible and prospective partners. These entities often outbid other applicants who are otherwise more suitable but are unable to match their price quotations. The intersection of politics, business and social status also adversely affects the PPP model in the state. This was especially apparent in the NGO sector in the state; several NGOs owned or controlled by local politicians, business people or strongmen from the region got a significant fillip from the MNGO scheme provisioned under the NRHM. It was found that some of them were misusing public funds for their own personal benefit.

Engagement of the government with the private health sector is extremely important, especially in a market dominated health system like Bihar. People depend on the private sector for fulfilling a wide range of their health needs. However, it is also well-established that private healthcare is more expensive, exploitative, urban-centric and profit oriented that puts a huge financial burden of healthcare on people. Therefore, the ultimate aim of these engagements should be to ease that burden, one of the ways that can happen is by strengthening the public health system in the long run. In case of Bihar, however, it seems like the engagement has made the government more dependent on the market for providing healthcare to its people and has not contributed to health system strengthening either.

The claim that PPPs are better at provisioning of healthcare than the public sector is yet to be established with evidence. Their advocates argue that partnerships can offer better-quality infrastructure and services at 'optimal' cost and risk allocation. However, the evidence is not there yet. Its inexplicable that none of the organizations that promote and implement PPPs have done any comparative studies like a cost-benefit analysis of a PPP and a public sector intervention to substantiate their claim. Health activists and researchers have criticized partnerships for diverting resources from public actions and distorting public agendas in ways that it favours private companies.

Why should a country or a government opt for public-private partnerships instead of strengthening its own capacity? The evidence that PPPs are better at improving health outcome of populations compared to the public health system is either lacking or is unconclusive at best. Agencies like the world bank, who have been at the forefront of the PPP movement in the health sector have not undertaken evaluation studies or conducted a cost-benefit analysis of PPPs that could prove that they are more efficient than the public health system.

This research also confirmed that a state's own institutions must be robust in order for it to have a sustainable and effective PPP mechanisms. A public-private partnership is not just an arrangement between two entities, actually it involves a network of relationships that include technical and financial advisers, funding agencies, investors, government departments as well as people who are going to avail the services offered by the partnership. A weak state lacks the capacity to effectively manage these networks and ends up endangering the partnership itself. If a PPP is expected to combine the strengths of the public and the private sector, the weaknesses and failures of each are also bound to affect the partnership. A partnership cannot be effective until these weaknesses are acknowledged and minimized. If the private healthcare sector in a state is known to be unethical and engage in malpractices, the partnerships are destined to have these issues as well unless mechanisms are in place to address those. Similarly, if the public health sector in a state doesn't acknowledge that improving people's health status and ensuring their good health is their responsibility, the partnership will also remain devoid of its public health responsibilities.

Successful PPPs must be more than mere tools for market expansion; and they have the potential to actually contribute towards mutually agreed goals provided the state maintains clarity of expectations from the partnership, keeps people's interest as the ultimate goal and

ensures that effective monitoring mechanisms are in place. Several of its own reports have laid down criteria that can be followed to have a pro-people PPP policy in place.

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